South Carolina
Department of Mental Health

Annual Report
1996-97

DMH South Carolina Department of Mental Health

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State Director of Mental Health

MISSION STATEMENT

The men and women of the S. C. Department of Mental Health, in partnership with consumers, families and their diverse communities, will assist citizens with mental disorders to improve the quality of their lives.

November 12, 1997

It is a pleasure to present the South Carolina Department of Mental Health's annual report for fiscal year 1996-1997.

As I came in April of 1997, the bulk of activities described in this document occurred before I began my tenure as director of the South Carolina Department of Mental Health. However, I believe the activities that are described in this document provide a clear indication of why I was so eager to come to South Carolina

This state is providing high quality mental health services. In a number of areas, this state is a national leader. For example, our deaf services system is the gold standard by which others are judged. The ROADS program is an excellent system of care for providing mental health services to isolated, rural populations. The family preservation effort in this state has been extremely successful.

While I could go on and on, the point is this is a good system of care. However, it is not a perfect system of care. I believe there are a range of clinical and administrative areas where this system can do better for the mentally ill of South Carolina.

I look forward to working with our clients, our staff and the concerned citizens of South Carolina to produce a system that offers an even higher quality of care in the years to come.

Stephen M. Soltys, M.D.
State Director

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Overview

The S.C. Department of Mental Health (DMH) takes the view that most people who have a serious mental illness do better clinically when treated in the community. People with mental illnesses need and require close family and community support. They get better faster and stay better longer when they receive services in their community, if these programs are reasonably funded, well organized, and easily available.

To that end, the Department focuses efforts on delivering services to people with serious mental illnesses as close to home as possible, rather than disrupting their lives by sending them to large, central hospitals miles away from home.

To provide mental health services to the citizens of South Carolina in an efficient and effective manner, DMH is divided into three major divisions and seven offices.

The largest of those divisions, the Division of Clinical Services, has two major sub-divisions — Community Mental Health Services and Inpatient Services.

Under Community Mental Health Services, the state is divided into 17 areas called catchment or service areas, with a comprehensive mental health center located in each area.

Each center is governed by a local administrative board that operates within policies and guidelines set by DMH. These centers serve the state's 46 counties through main facilities and a network of clinics and outreach programs.

The community mental health centers serve as the entry point into the state's public mental health system. However, when a center's resources cannot meet a patient's needs, the center refers that patient to one of the department's nine major inpatient facilities, which compose Inpatient Services.

The Department of Mental Health is governed by the seven members of the S.C. Mental Health Commission, who are appointed for five-year terms by the governor, with the advice and consent of the state Senate. They are: Mrs. Elizabeth Forrester, chair, who is from Georgetown; Vice-Chairman James E. Whitford, Sr., M.D., from Goose Creek; Mrs. Brenda H. Council from Orangeburg; Mr. Leon Finklin from Columbia; Mr. Douglas F. Gay from Rock Hill; Dr. Herman G. Green from Six Mile; and Mrs. Lisa H. Stevens from Greenville.

S.C. Department of Mental Health
Mission Statement

OUR MISSION

The men and women of the S.C. Department of Mental Health, in partnership with consumers, families and their diverse communities, will assist citizens with mental disorders to improve the quality of their lives.

OUR PRIORITIES

The department will give priority to adults and children with serious mental illnesses and serious emotional disturbances and will fulfill its legislative mandates. We will work cooperatively with other agencies, both public and private, to assure continuity of services based on the needs of the individual.

OUR VALUES

Respect for the Individual

We believe that the people we serve have the right to personal dignity, respect and the highest possible degree of independence. We are committed to services that promote the individual's quality of life, focus on the individual's strengths, foster independence, and honor the rights, wishes and needs of the individual.

Support for Local Care

We believe that people are best served within their home community. We are committed to the availability of a full and flexible range of coordinated services with the community as the primary focus of care, and services that appropriately meet the needs of the individual in the most normal environment possible. We are committed to programs which build upon the local support provided by family, friends, other agencies and the community, and which offer employment, leisure, learning, residential and psychiatric/rehabilitation services within this supportive framework.

Professionalism and Commitment to Quality

We believe that we should encourage and reward excellence. We will create a work environment which inspires and promotes innovation and creativity, supports education and research, and continually seeks more efficient and effective ways to provide clinical and administrative services. We are committed to a skilled and ethical work force, culturally competent and dedicated to the highest standards of courtesy, understanding and respect. We will be an agency worthy of the highest level of public trust.

Office of the State Director of Mental Health
Stephen M. Soltys, M.D.

Major Accomplishments in FY 96-97 included:

*** Number of Clients Served**

In FY 96-97, the South Carolina Department of Mental Health served 90,077 clients in its 17 community mental health centers and had a total of 11,566 admissions to inpatient hospital services.

*** Toward Local Care Initiatives**

In the beginning of FY 96-97, the fifth year of the TLC initiative, 14 projects from 11 community mental health centers were funded at a total of $4.2 million. DMH included $1.7 million in its FY 97-98 budget to start additional TLC projects.

As of June 30, 1997, the TLC projects had served 297 clients and were actively serving 205 consumers. Fewer than 10 percent of the clients have returned to long-stay state institutions, and client perceptions of their quality of life have improved.

The average net cost is $16,111 per TLC consumer per year, compared with the net average of $74,000 per year to serve the same consumer in a long-stay hospital.

*** Accreditation**

In April 1996, DMH Community Mental Health Services notified all mental health center directors that they should be accredited no later than July 1, 1998, by either the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or by the Commission on Accreditation of Rehabilitation Facilities (CARF).

Sixteen centers selected CARF and one chose JCAHO. Eleven of the 16 centers seeking CARF opted to be accredited under the 1996 standards, and five opted for the 1997 standards.

Centers participated in three training opportunities on CARF standards. A CARF Coordinators Committee was formed to address concerns and ensure that the standards are correctly interpreted and systems barriers are met.

*** DMH Celebrates 175 Anniversary**

Throughout 1996, the agency celebrated its 175th Anniversary with numerous projects, publications and special events, culminating with a Grand Celebration December 20, 1996, at the Chapel of Hope on the S.C. State Hospital grounds.

Major Goals for FY 97-98 are to:

* develop an overall strategic plan for the future with input from consumers and their families, advocacy groups, center board members, S.C. Mental Health Commission members, staff and focus groups;

* develop a written, comprehensive listing of programs offered by DMH along with a comprehensive listing of the costs by site, average cost per annum and

representative unit cost;

* increase the resources for mental health services for children, adolescents and their families including the growth of school-based services and an increase in services for young adults with serious emotional disorders;

* develop a more effective system for the development and coordination of contracts and grants and the careful monitoring of the services provided by contractors and grant recipients to ensure services are properly delivered;

* develop a written, comprehensive plan to assure that all programmatic initiatives have outcome measures that are being followed to determine the impact of a program;

* develop systems to improve quality of services to adult patients in the areas of employment, dually diagnosed needs (substance abuse-mentally ill) and reducing the occurrence of adverse incidents; and

* adapt to cuts in Disproportionate Share Funds made by Medicaid to hospitals that serve disproportionate numbers of indigent patients by searching for new revenues, examining existing programs or possibly reducing services. (For DMH, the first cut translates to $740,000 in FY 1999 and approximately $4.5 million in FY 2000.)

Communications

The Office of Communications continued its mission to provide timely, accurate information about the Department's services and programs to the various publics it serves and to help eliminate the stigma of mental illness.

To help meet those goals, the Office of Communications last year published four issues of *Focus*, its award winning newsletter that explores major new programs and services offered by the Department.

This publication is distributed quarterly to 2,500 readers throughout the state as well as to certain national organizations. *Focus* is but one of several publications produced annually by the Office of Communications to keep employees and other publics abreast of Department activities.

In addition, the Office of Communications continued to inform the statewide media of new developments within the Department and responded to over 100 media inquiries. About 500 news items concerning the Department were printed in newspapers throughout the state.

The Office of Communications routinely submits news releases and article ideas to approximately 18 daily and 101 non-daily newspapers, the South Carolina Radio Network and to television stations.

In a further effort to help eliminate the stigma of mental illness through public education, the Office of Communications manages the Department's Speakers'

Bureau. In the last year, the bureau placed 12 speakers throughout the state and included presentations at several colleges and universities as well as various civic and community locations.

Also, the Department's community mental health centers regularly provided speakers for needed functions within their areas.

As part of its commitment to public education, the Office of Communications, along with the Division of Clinical Services, chairs a statewide Consultation, Education and Prevention (CE&P) committee with the Department's 17 community mental health centers.

The CE&P program was implemented in 1991 to provide consumers, their families and all citizens with information about the treatment, management and prognosis for mental illness. Last year, five community mental health centers were awarded $2,000 grants each to develop programs in support of the CE&P mission.

A major project last year for the Office of Communications was the coordination of the Department's recognition of its 175th anniversary. The year-long celebration included burial of a time capsule on the grounds of the State Hospital; design and production of a commemorative flag, quilt and print; reading of a Concurrent Resolution in the South Carolina Legislature; and offering various educational programs by community mental health centers across the state. The activities concluded in December with a Grand Celebration on the grounds of the State Hospital.

The Office of Communications also manages the Department's Community Resource Development, or volunteer, program. Many of the community mental health centers and inpatient facilities provide consumers and their families services through volunteer programs. Last year, approximately 7,000 volunteers provided than 146,000 hours of services to the Department's consumers. These volunteers produced about $2.3 million in service time and donations.

General Counsel

The Office of General Counsel provided legal advice on a broad range of issues during the past fiscal year, including many of the state plan goals. Attorneys from this office advised facility and agency managers on managed care issues, including contracts for mental health centers and inpatient facilities to join provider networks. The office also worked closely with agency staff preparing the mental health centers for CARF accreditation.

The Office of General Counsel conducted a review of the state's involuntary commitment laws in light of expected issues in a managed care environment and proposed numerous technical amendments to the code. This review will continue next year.

Over 30 presentations were made to groups in the Department and in the community on issues with legal components. The Office of General Counsel also was involved in the efforts to develop a central credentialing process for the agency.

The Office of General Counsel will work with other divisions of the Department on implementation of many of the Department's FY 97-98 goals, including:

* participating in training staff of inpatient facilities and mental health centers regarding managed care;

* working with the Criminal Justice System to improve collaboration in the treatment of persons with mental illness in that system;

* providing treatment staff with training on alcohol and drug abuse confidentiality issues; and

* continuing joint initiatives with the Department of Juvenile Justice.

Internal Audit

(The Office of Internal Audit is directly responsible to the members of the S.C. Mental Health Commission -- see organizational chart, page 78.)

A primary objective of the Office of Internal Audit is to engage in audit activities to support the agency's mission. An "audit of the business" approach seeks opportunities to increase revenues, decrease expenses and maximize efficiencies within the organization. The continuous monitoring of agency activities helps ensure compliance with established policies and procedures.

Audit activities include hospital facilities, community mental health centers, contracts, data processing reviews, compliance audits and special projects. A formal risk assessment program provides improved audit selection techniques.

Goals for the coming year include a continuing shift of emphasis to the more significant opportunities for audit and increasing the effectiveness of the Office of Internal Audit work.

Public Safety

Public Safety has completed the project of consolidating and moving a number of its organizational components to the LaBorde Building. By doing so, it has greatly improved the overall efficiency of Public Safety and has enabled us to better utilize our personnel and resources to serve the Columbia area.

Throughout this past year, our staff investigated over 579 cases and recovered stolen properly or funds valued in excess of $8,597.

Our goals are to retain those officers hired within the Department and secure better equipment that we might continue to provide a safe and secure environment for clients, employees and visitors throughout the state.

We have additional responsibilities to provide security for the Department of Juvenile Justice (DJJ) program, which seem to continue growing. Because of certain guidelines set forth for the DJJ children. we must assist them in their activities, trips off-campus and on campus and provide coverage during school hours.

From March until August 1997, Public Safety responded to over 700 calls for DJJ.

Division of Planning/Budgeting/Administration

Administrative Support Services

Administrative Support Services is responsible for providing consolidated administrative support to our inpatient and community treatment programs. It is comprised of four areas:

Physical Plant Services - includes professional engineering; special and preventive maintenance; construction and renovation; building codes and licensing standards; energy use and conservation;

Nutritional Services - includes clinical nutritional services; food production; food delivery and food serving;

Departmental Services - includes the departmental warehouse; consumable inventory; fixed assets; surplus property and Physical Plant Services supply functions;

Management Services - includes vehicle management; grounds maintenance; printing; microfilming; forms control; residential housing; vehicle and building insurance; and special projects.

Physical Plant Services had many significant achievements during FY 96-97. Community mental health centers are busy with Department sponsored capital development plans. Staff are occupied with the management of various projects — assisting with architectural selection, land selection, negotiating the project through the various steps that are required by the Budget and Control Board and generally managing the project until completion.

In the northeast sector, Tri-County's Dillon satellite and Pee Dee's Lake City satellite have been completed and occupied. Chesterfield's satellite is being reviewed by the state engineer prior to bid.

In the Low Country, Orangeburg Mental Health Center's main office is under construction and approximately 50 percent complete. Two of three satellites in their service areas, Denmark and Holly Hill, are occupied and serving clients. The third, a Calhoun County clinic in St. Matthews, is approximately 75 percent complete.

In the Upstate, Beckman Mental Health Center has occupied their Laurens satellite and has purchased land for a Newberry satellite. Spartanburg Mental Health has identified a site for their facility, and final negotiations are underway. Catawba

Mental Health Center's new Lancaster satellite is completed and occupied. Piedmont Mental Health Center is being reviewed by the state engineer and will be out for bid shortly for a new facility in Simpsonville.

In the Midlands, Lexington Mental Health Center's child and adolescent facility is under construction, and construction is to begin immediately on a main center adjacent on the site. Also, Columbia Area Mental Health Center has an ongoing renovation of their Independence House on Carter Street and had an administrative office building recently completed on the same campus.

On the Columbia and northeast campuses, Physical Plant Services Maintenance section has been diligent and dedicated to providing quality services. The Building Managers, General Maintenance and Specialty Shop personnel have been working aggressively to ensure the facilities provide a satisfactory environment for patients and staff. They have worked closely with other DMH staff to ensure that JCAHO, DHEC, Advocacy and Fire and Safety standards are met and maintained.

Several permanent improvement projects are being managed by the Physical Plant Services project management staff for the inpatient facilities. Renovations at Bryan Hospital, Stone Pavilion, Department of Administrative Services Building and Harris Hospital are either in process or in the completion stages. The Fire Alarm upgrade is progressing with several campuses complete and several more in design. Utility system upgrades are being designed and awarded to include replacement of underground storage tanks, water supply improvements and sewer line replacement.

Physical Plant Services' goals for the coming fiscal year are the timely completion of the above projects and continued quality and preventive maintenance to buildings and systems in our charge.

Nutritional Services started the Cook/Chill System in January 1997. The system offers flexibility in meeting the nutritional needs of clients and improves the work environment of the employees of Nutritional Services. The mission of this department is to provide total nutritional care for its clients.

During FY 96-97, Nutritional Services performed an Annual Food Acceptance Survey. Of the 108 foods suggested by the residents, 82 were on the current menu. Since that time, additional menu items have been added to the cycle menu based on the residents' preferences.

The Quality of Work Life Committee has played a key role in improving the communication process and work place relations with the employees of Nutritional Services. We observed National Health Care Food Service Week in October 1996.

Other goals were met by providing special meals for holidays and tray favors for the clients. In addition, several other functions were held to benefit our employees in the transition to cook/chill.

Nutritional Services will continue on a daily basis to meet our mission goals, which are to provide optimal nutritional care for our clients.

Our goals for FY 97-98 are to:

* continue to provide optimal nutritional care for our clients;

* improve the employee working conditions and job satisfaction through the Quality of Work Life Committee;

* implement new budgetary controls and reduce labor cost for Nutritional Services; and

* develop and implement a menu for clients with swallowing difficulties.

Financial Services

The Patients' Personal Affairs Medicaid Outreach Program continues to maximize Medicaid revenue for inpatient children's services and the Children's Residential Treatment Facility and has expanded to Tucker/IMD. Work continues toward more automation of activities to improve timeliness, where possible, in establishing patients' eligibility for benefits.

The community mental health center entitlement specialist program continues to increase the number of Medicaid-eligible clients served and to increase the amount of Medicaid reimbursement received by the Department.

Technical assistance, i.e., training on eligibility criteria for Medicaid, Social Security, Supplemental Security Income, as well as individual case consultation, continues to be provided to the inpatient facilities constantly by Patients' Personal Affairs (PPA) Resources staff. The staff also provides this same technical assistance to the community mental health centers and inpatient facilities in order to secure maximum benefits for patients who are to be placed in the community.

PPA Resources and Reimbursement sections have reorganized to provide easier access to the public in dealing with patients' financial affairs and to establish a smoother billing stream.

Work is also underway to obtain a new automated patient registration/ billing system.

In addition, staff will be working closely with the new corporate compliance officer to assure adherence to federal regulations.

During FY 96-97, the Cost Development Section successfully prepared and filed electronically 20 federally mandated home office and inpatient hospital cost reports. Nine of these were Medicare and 11 were Medicaid.

All of these reports were submitted before their respective deadlines and justified over $47.6 million in federal inpatient revenue to DMH for the year.

Also during the past year, the *DMH/CMHS Rate Justification Study* was completed

by Cost Development and submitted to Health and Human Services Finance Committee.

This report is used to support an additional $46 million in Medicaid outpatient revenue received by DMH community mental health services annually.

In FY 97-98, Cost Development will continue its endeavor to maintain the timeliness, increase the accuracy and improve the efficiency of its accounting procedures.

The Accounting Section completed a major revision to the Agency's Chart of Accounts for FY 96-97 and implemented additional refinements for FY 97-98. Additional projects currently underway include changes to the financial system to allow tracking of expenditures by contract and formation of a Quality Team to review and make recommendations for improvements in the voucher processing system.

The Procurement Office has completed the training sessions for the changes in the procurement authority and the introduction of the new F-14 (Direct Purchase Order) form. Feed back on the new form has been positive.

The recertification process has been completed. All areas that requested assistance have been accommodated.

During the ensuing months, the initial audit phase will be completed. Each center and facility will be receiving the results of the procurement audit.

Changes to the Procurement Code have taken place, and it is necessary for Procurement Office personnel to study the changes very closely. The changes will not have an affect on the purchases made by certified individuals in the centers and facilities.

The Contract Section, working in cooperation with Computer Services, completed the development of the expanded DCON database begun during FY 95-96.

The new database will allow management throughout the Department on-line access to current information on the Department's contracts and leases.

During FY 96-97, the Contracts Section processed over 600 contracts, leases, memorandum of agreement, amendments and grant applications through the contract review and approval process.

In addition, the Contracts Section assisted the Procurement Division by soliciting 18 contracts by the competitive request for proposals procurement methodology.

Projects for FY 97-98 will focus on assisting in the training of center and facility staff in the proper use of the DCON database and their responsibilities for contract monitoring delineated in DoFS Policies and Procedures.

The Policies and Procedures Section has issued nine transmittals (updates) to the *DoFS Policies and Procedures Manual* to date. Review of current policies and procedures and the evaluation of additional subjects for inclusion in the manual have been ongoing with the objective of achieving sound fiscal practices throughout the agency.

A primary focus of the Policies and Procedures Section has been to provide both

formal and individualized training to organizational units specifically concerning payroll and time keeping activities. Training classes, monitoring activities and individual contacts for assistance have been beneficial in identifying those problematic areas where training is most needed.

Another focus this year has been the analysis of our Patient Registration and Accounting System needs to develop a Request for Proposal for a new integrated system. Reviews of other financial processes and systems have also been performed as deemed necessary.

Human Resource Services

The goals accomplished in FY 96-97 include:

* Policies required for the new compensation system were implemented for both the community mental health centers and inpatient facilities.

* A review of all agency internal titles was partially accomplished. Titles were reviewed for some occupational groups. More time in the new system is necessary before reviewing other groups.

* Worker's Compensation is analyzing information accumulated through the CompWatch Program and making this information available to the centers and facilities to reduce our workers' compensation premium.

* The decentralization of the hiring process has been accomplished. Human Resource offices in all of our centers and facilities now receive and evaluate applications, forward them to hiring supervisors, and handle pre-employment processing of applicants selected.

* The Employment Office in the Central Office now has the responsibility to provide technical assistance and to monitor and review information submitted to ensure the integrity of the system and processes developed.

* Formal training has been provided to all staff affected by the decentralization, and additional training has been made available on an as-needed basis to any new and existing staff who have requested it. Evaluation of the system is on-going.

* On-site visits have been made to a majority of the centers and some of the facilities. During these visits, a random sample is pulled of vacancies that have been filled, and they are followed throughout the entire process to test the system as to whether appropriate procedures have been followed. A written evaluation of the system is compiled and copies are sent to the Human Resources staff of the centers/facilities, as well as to the person having overall responsibility for the Human Resources function. In locations that are experiencing compliance problems, a copy of the report is sent to the regional director. These evaluations will continue on an annual basis.

* Policies and procedures in Employment and Employee Relations are still under review. Completed revisions of major policies include grievance and EPMS.

* The Employee Assistant Program's (EAP) list of providers in each catchment area has been expanded to adequately cover that area.

* The EAP staff, one full-time and one part-time, served approximately 140 new clients this year. Eighty-five percent of the new clients came from the facilities. The remaining 15 percent were from the centers. Thirty-five percent of the new clients were either clinical/professional staff or administrative. The balance were primarily mental health specialists or support services.

* EAP has shifted emphasis from assess-and-refer to direct therapeutic services. This was done partly due to the requirement of insurance companies that referrals to counselors be from a medical doctor and partly to the $30 cap on payment to counselors. EAP addressed this issue with appropriate personnel and has been assured the medical doctor referral provision will change to a list of providers in 1998.

* The S.C. Public-Academic Mental Health Consortium completed and approved work force reports describing knowledge, skills and attitudes needed by staff working with persons with dual disorders, with children, adolescents and their families. The work force reports concerning aging individuals with severe mental illness and management skills for managed care are still being written.

* The Continuing Education Committee of the S.C. Public-Academic Mental Health Consortium developed a plan for implementing the recommendations of the dual disorders work force report. Two community mental health centers are implementing one of the adult community rehabilitation and support report recommendations concerning multi-disciplinary teams.

* The Southern HRD Consortium held a planning conference for a second National African-American Behavioral Healthcare Work Force Development Conference in Norfolk Nov. 8-10, 1996, at which time an Historically Black Colleges and Universities (HBCU) Academy concept was developed and presented to the Center for Mental Health Services. The federal budget did not support a second conference for 1997; therefore, the HBCU Academy at Norfolk State University was canceled.

* The S.C. Public-Academic Mental Health Consortium has contracted with Arkansas, Mississippi and Oklahoma to complete a needs analysis and design training materials for mental health and other state agencies that provide entitlement services to adults with serious mental illnesses and children, adolescents and their families with serious emotional disturbances. The Mississippi Alliance for the Mentally Ill designed and produced, with assistance from one of the Jackson television stations, a public service announcement educating the public about mental illnesses and

emotional disturbances.

Major goals for FY 97-98 are to:

* consolidate community pay policies and inpatient pay policies into one uniform pay plan for the agency;

* develop a bonus award policy for the agency;

* complete review of internal titles for the agency;

* identify the facilities and centers in need of training and provide on-site training in the areas of retirement and insurance;

* further refine the *Jobs Available Bulletin* and to purchase and utilize an electronic announcing system that will be more customer friendly;

* purchase an imaging system for the Employment Office that will allow for a more efficient storing and retrieval of applications;

* identify and develop a more effective recruitment program, specifically targeted toward hard-to-fill positions;

* develop a tracking mechanism to more readily identify trends and to develop statistical information on disciplinary actions, grievances and EEO complaints;

* refine and develop supervisory training in the areas of EPMS, sexual harassment and family medical leave;

* continue training for supervisors in centers with low rates of referrals; however, the EAP will focus more on providing more direct assistance to the supervisors in dealing with problematic or needy employees;

* work with providers of intensive outpatient treatment and with Blue Cross and Blue Shield in order to bring about better insurance coverage for intensive outpatient services. (EAP has successfully negotiated a discounted rate for intensive outpatient services with the two major providers in Columbia, but the state plan treats intensive outpatient services, which typically cost from $100 to $150 per day, as an outpatient visit, which is limited to $30 per visit. Our negotiated discounted rate is $85, leaving a co-pay of $55 per day, which is $220 per week, excluding family weekends. This is cost-prohibitive for most of the EAP clientele.);

* develop a protocol beginning with Columbia Area Mental Health Center to better assist clinical staff who lose patients to suicide;

* conduct three surveys which will examine DMH's new hires and their preparation for professional positions, internships and assistantships with resulting hiring practices of DMH, and employee contribution to Consortium academic institutions through teaching and supervision;

* complete two Work Force Task Reports, *Management Skills for Managed Care* and *Aging and Mental Health*;

* complete the ADA Replication Project, including the evaluation component and

submit the products and results to the Center for Mental Health Services; and

* assist the director of the Office of Special Projects with the Education Task Force survey and recommendations.

Division of Quality Improvement/Outcomes

During this year, the Office of Quality Improvement/Advocacy in the State Director's Office became the Division of Quality Improvement/ Outcomes.

The Office of Quality Improvement/Advocacy continued its focus on the services and clinical systems of the Department. Included within this focus is physician credentialing, leadership in moving the system to an Organized System of Care (Managed Care), Community Residential Care Facility monitoring and service development and other quality initiatives including data about the persons we service as they make contact with the variety of other service systems in the state.

Each of these services of the office is in keeping with the mission of the Department and the State Plan goals.

The reorganization of the Department's management resulted in several additions to the office and a designation of the resulting unit as a division.

The Office of Cultural Affairs, the Office of Consumer Affairs and the Office of Total Quality Management have been joined with the Office of Quality Improvement/ Advocacy to form the division.

The organization reflects a commitment to a comprehensive and integrated response to the rights of the patients, the acceptability of the services to the ever increasing variety of consumers and the support for an empowered destigmatized consumer involved in their own care. The actual integration of the offices was under development by the end of the year. In this process, the division has specific goals for each of the previous offices.

The designation of the division in the reorganization plan also resulted in some fundamental changes to the role that had been in place. The State Plan and the strategic planning effort are now located in the division. The division has worked to merge these planning functions into a process that is more comprehensive.

A second fundamental change reflected in the new division title is the focus on outcomes.

In preceding years, the Office of Quality Improvement had been involved in the development of a data base for outcomes.

A State Reform Grant and a Feasibility Study through the Center for Mental

Health Services and the National Association of State Mental Health Program Directors have formed a platform for outcomes measurement. With the designation of the division, the Department has made a major commitment to the production of outcomes.

In today's accountability oriented atmosphere, this timely emphasis has made such a commitment necessary. This next fiscal year requires a system built on outcomes. It is axiomatic that areas measured best result in most improvement.

Division of Clinical Services

Children, Adolescents and Their Families

The vision of Children, Adolescents and Their Families Services (CAF) remains to develop a statewide system of mental health services to address the various needs of our state's children, adolescents and their families experiencing emotional, behavioral and psychiatric disorders. This vision is built upon the premise that a broad array of services must be made available which are child centered, family focused, community based and culturally competent.

Once this system has been developed, every effort must be made to infuse the various elements of that system into all existing and future child serving systems (juvenile justice, education, child welfare, etc.).

Stated another way, if children and their families are unwilling to come to us, then we must employ strategies which allow us to take our services to the children and families of South Carolina who will benefit from our care.

Following are a few of the major accomplishments during FY 96-97.

The Village Project funded through the Bureau of Children, Adolescents and Their Families within the Substance Abuse and Mental Health Administration continues to receive national recognition. Various evaluators and consultants from around the country as part of the nationally funded evaluation of these demonstration projects have given The Village the highest marks and lavished upon it many accolades. The success of The Village resulted in receiving a supplementary grant specifically to develop services for children zero to five. With only one year remaining on the grant, the primary focus is to decide upon which elements of The Village should be replicated across the entire state, which would have the greatest impact upon enhancing the overall service system for children, adolescents and their families. The federal site visit was excellent, resulting in $50,000 to be used to target South

Carolina's specific data.

Between FY 96-97 there was a 9 percent increase in the total number of children served through our community mental health centers and hospitals.

Specifically, FY 95 saw 29,024 children, adolescents and their families served, while FY 96 saw 29,692. With the emphasis upon community-based services, the centers' children/families served increased from 26,419 in FY 95 to 29,692 in FY 97.

In the area of Human Resource Development, between the period of FY 96-97, 385 child mental health professionals were employed through the community mental health centers.

During FY 95-96, while there was a slight decrease in number of child mental health professionals employed, of particular note is that more than 30 percent of them are professionals of color with the dominant group being African-American.

At the end of FY 96, there were 63 child mental health professionals working within119 schools.

At the end of FY 96, there were 97 child mental health professionals working in 161 schools -- a 54 percent increase.

During FY 96, DMH received a five-year grant from the Federal Department of Health and Human Services Maternal Child Health Bureau Adolescent Branch to coordinate health and mental health services to students with emotional problems at the state level and at four South Carolina school districts (Lexington, Hampton, Berkeley and Chester counties).

Local project coordinators have been hired in the districts to assess the students' health and mental health needs and help students receive these services. This project involved hiring 12 student interns from Benedict College and South Carolina State University, historically black colleges in South Carolina to work with students in the four school districts.

This project, given the needs of the two school districts chosen and our first formal training relationship with historically black colleges and universities, have positive evaluations on the federal level and one team member presented at the First National Conference on School-Based Mental Health Services in Baltimore in September 1996, and the other at the National TA Training for School-Based Mental Health Services.

In the area of early intervention, services for children between ages 0-3 remains a priority within the department. This federal initiative, called BabyNet within the state of South Carolina, again expanded within the department. We have a total of seven BabyNet child mental health professionals.

To date, we have a total of three Mental Health Round Tables in Dorchester, Greenville and Columbia. These projects are developed to staff problematic cases

from a mental health perspective.

Because of the recent early intervention credentialing program, one of our BabyNet child mental health professional has received her Early Intervention Certificate. All of the BabyNet child mental health professionals are working toward getting this certificate. To date, services have been provided to approximately 350 children through DMH's Part H Program.

With the ending of the Child and Adolescent Service System Program (CASSP) Grant, the department continues its commitment to the training of child mental health professionals. To this end, $100,000 was made available to the William S. Hall Psychiatric Institute to continue the training of child mental health professionals from the community mental health centers.

The Institute hired a coordinator for this initiative, and under her direction, has coordinated the training of 31 child mental health professionals. To date, a total of 75 child mental health professionals across the state have gone through this training, 65 have completed at least 150 hours, while 10 completed 50 hours or less.

The department also remains committed to the continued development of its Parent Support Network. Here again, with the conclusion of the CASSP grant, the department has made available funds to continue this initiative. These funds have helped to maintain 20-parent support groups across the state and trained 13 additional parents to facilitate more parent support groups around the state.

In February 1997, the Mental Health Association of South Carolina was awarded a contract through an open RFP. They are using the funds to establish a Federation of Families for Children's Mental Health in South Carolina. To date, they have hired a director and an outreach coordinator and recruited a number of parents to serve on their State Parent Advisory Committee.

The department continues to work closely with the Department of Juvenile Justice around its federal overcrowding lawsuit. During FY 96, the outpatient program under the auspices of Hall Institute was moved to Unit 180 and became Options, a residential treatment facility.

Female offenders have priority at Directions, the existing Hall residential treatment facility. Two RFPs were developed and released for a 20-bed residential program for very aggressive and violent youth and a second 20-bed residential program for sexual offenders. Justice Resource Institute was awarded the contract and is scheduled to open when facilities are ready.

During this period the department was not involved in the clinical placement of children out-of-state for the first time in years.

A significant issue yet to be addressed is the development of both residential and community-based services for young adults. A completely different, age, clinical,

educational/vocational and social array of services must be developed for young people between the ages of 16 and 24.

The department submitted a $3 million grant proposal to pilot community-based services for young adults in the Greenville, Anderson, Oconee and Pickens areas.

The basis of the initiative is supported community living with clinical services and a strong vocational-educational component. The department and its sister agency (Continuum of Care) provided the match funds. Should the grant not be funded, a smaller pilot will be pursued.

The clinical responsibility of children and the fiscal responsibility inherent in clinical responsibility was a major issue starting to be addressed this year. Decentralization, with local accountability through the mental health centers, will be a primary policy and program undertaking for the next year.

Long Term Care/Elderly/Developmental Disabilities

DMH continues to recognize and take specific measures to increase the availability of specialized skills for the mature adult population by providing geriatric specialty training as part of the Governor's Summer School of Gerontology at Winthrop University. Of the 34 participants attending, 29 were staff of DMH mental health centers and facilities. The remainder came from other state agencies having vested interest in mature adults and the geriatric populations.

The primary goal of this 30-hour classroom course is to provide professional education and leadership to staff members who are involved in meeting the needs of the dramatically increasing older adult population in the state.

In addition to the five-day class work schedule, each participant was required to design and be prepared to implement a work site related program upon return to the job site.

The course was conducted by six mental health professionals and a private practice pharmacist from the community.

As a result of a positive response from a recent survey instrument, an Advanced Geriatric Specialist is planned for the spring of 1998.

Interagency collaboration, partnerships and program planning continue to be a significant responsibility for this division.

Activities with the Governor's Division on Aging include participation in the design and implementation of the Gerontology Summer School, Primary Prevention Conference in October 1996, geriatric conference in November 1996, consultation education and prevention and chairing the Alzheimer Resource Advisory Council.

The Advisory Council is a 17-member body created by the state legislature in April

1994. The purpose of the council is to provide statewide Alzheimer service activity, coordination, leadership, collaboration and clinical assistance to both public and private agencies as well as to provide information and referral services to care-giver family members.

There has also been considerable collaborative activity with the National Association of Mental Health Program Directors Elderly Division Executive Committee and implementation of the national conference in Salt Lake City in August 1997. DMH will host the 1998 National Conference Charleston in the fall.

Services to family members and care givers focus on consultation and assistance in acquiring information concerning placement opportunities, care-giver training, referrals to an appropriate agency, home safety issues and the normal aging process.

A top priority with this process is that of providing an array of resources to maintain an individual in the home with an increased quality of life. This approach continues to strengthen the relationship within the family constellation and also relieves significant pressure upon admission to DMH nursing home facilities.

DMH continues to enjoy both regional and national recognition with regard to the use of telepsychiatry equipment for services to hard of hearing/deaf clients. This success has increased the opportunity to expand the telepsychiatry program of services through a partnership with Health and Human Services.

Expansion equipment has been evaluated in terms of application and placement and the order and distribution of this equipment are expected to be completed in September 1997. The expansion will encompass all DMH mental health centers and facilities.

DMH/Department of Disability and Special Needs (DDSN) Liaison Activity

Liaison services with DDSN include assessment of dual diagnosed clients, treatment intervention strategies, inservice education to both agencies and representation on the Developmental Disabilities Council and Prevention Committee. DMH is also involved in participation in the Children's Case Resolution Committee staffings as required as well as the Advisory Council on Child Abuse AMD Neglect to initiate awareness campaigns regarding the risk of abuse and neglect of children with developmental disabilities.

A proposal has been submitted to establish a quality improvement group of identified MI/DD staff from the mental health centers of Region B. The goal would be to implement this quality improvement group successfully and then to consider implementing similar groups in the other three regions. Another goal would be to develop and complete a workshop on clinical assessment of people with developmental disabilities and mental illness to be made available to a multi-agency audience.

Hard of Hearing/Deaf Services

DMH is recognized nationally as a leader in the provision of services to persons who are both severely mentally ill and deaf or hard of hearing. Staff from the Department's Deaf Services program provide workshops and technical assistance to Department entities, to other states and at the national level.

DMH currently serves over 300 deaf and hard of hearing adults who have a severe mental illness, and children who are seriously emotionally disturbed.

Services to deaf and hard of hearing children and adults are available at each of the mental health centers in the state through a regional service delivery model.

Over 35 specialists in deafness and mental health work in program options including outpatient counseling, case management, psychosocial rehabilitation, children's services, residential programming and an inpatient unit at Harris Hospital.

Staff are recruited nationally and must demonstrate fluency in American sign language as well as knowledge of deaf culture. FY 96-97 saw the addition of a nurse in the upstate regional program. There are at least two counselor/case manager positions in each of the four DMH regions, in addition to a mental health counselor located at the South Carolina School of the Deaf and Blind.

An innovative telepsychiatry project has been successful in enabling clients across the state to have access to one psychiatrist who knows American sign language. This program will be expanded to all centers in the state during FY 97-98.

Additional technological enhancements anticipated in FY 97-98 include development of an Internet Home Page, telepsychiatry evaluation procedures and a statewide deaf client data base. In addition, a TTY crisis line service is available 24 hours a day for deaf people throughout the state. This continuum enables the delivery of full range of services to deaf and hard of hearing consumers.

Office of Pharmacy Consultation — Community Mental Health Services

Our registered pharmacist is involved in assessing and revising standards of pharmacy care in community mental health centers throughout the state. She has also identified and resolved a number of common concerns regarding pharmacy issues among the mental health center directors, medical directors and center quality assurance coordinators.

Problems identified this year have been resolved through the use of alternative measures such as partnering with local community pharmacies, proposal of a pharmacy benefit management program and the establishment of "DMH regional pharmacies" located in strategic areas throughout the state.

FY 97-98 goals for the Office of Pharmacy Consultation are to:

* maximize the use of pharmaceutical manufacturers patient assistance programs;
* redefine the role of consulting pharmacists from inpatient facilities; and

* pursue viable alternatives to the current system for providing pharmacy services to patients in the community.

The pharmacist is also the clinical services coordinator of the $1 million supplemental appropriation study of Atypical Neuroleptic Medications.

Additional staff training and information resource are also made available through the provision of a basic psychopharmalogical course, advanced psychopharmacological update and presentation of the psychiatric/mental health nursing refresher/review course for registered nurses conference.

Community Mental Health Services

Aiken-Barnwell Mental Health Center
(Aiken and Barnwell counties)

Aiken-Barnwell Mental Health Center had a whirlwind year. The Department of Mental Health announced its intention that all community mental health centers would be nationally accredited, and the center, like all centers across the state, began to prepare for this major undertaking.

Shortly afterward, Executive Director Bob Waters announced his impending retirement after 28 years with the center, and the board of directors and the Department embarked on a national search for a new director.

A long-standing deficit required significant attention to fiscal matters; center management decided to establish a productivity expectation for all clinical staff. Money problems and more stringent requirements for clinicians resulted in a number of employees leaving the center. The center's decision not to fill a number of the vacancies meant larger caseloads for remaining staff and the loss or reduction of some valuable services, including employment services for chronically mentally ill adults.

In the fall of 1996, the center decided to seek accreditation through the Commission on Accreditation of Rehabilitation Facilities (CARF) and had its "CARF Kick-Off" in December.

Also in December, the center's long-term assistant director, Bill Trezza, announced his resignation. In January, the board of directors and DMH selected a new director, Diane Cavenaugh, who had worked in the Washington State community mental health system for 21 years. Ms. Cavenaugh came on board in February.

The most pressing issue the center faced this past fiscal year was national accreditation. Preparation for accreditation took precedence over almost all other issues and proved to be an extremely positive experience as management, adminis-

trative and clinical staff evaluated all aspects of the center's operations in detail. Though a tremendous amount of work, this process enhanced the center's awareness of itself as a quality organization dedicated to providing consumer-oriented, effective and efficient services to persons with serious mental illness.

The other major change for the center in FY 96-97 was the completion of a new building in Aiken, which enabled the move of four sites into one. The building was designed (with lots of staff input) and built during the year, with the move planned for July 1997. In addition to a beautiful new building, staff were able to select all new furnishings for the new site. With all the difficulties staff faced during this past year, being able to move into a brand new building with all new furniture was a welcome morale-booster, not to mention the positive impact on consumers.

The center served 4,104 individuals in FY 96-97, and provided 49,170 consumer contacts. Despite the 19.7 percent decrease in clinical staff from FY 95-96, a monthly average of 1,238 persons were served, a decrease of only 4 percent from the previous year. As of June 30, 1997, the center had 75 permanent staff.

Specific goals outlined for accomplishment during FY 96-97 are outlined below, with the actual completion for each objective and the performance of the goal noted:

* reduce admissions to state inpatient facilities to a rate of 140 per 100,000 general population

Objectives:

A. Increase awareness and skills of after-hours on-call staff in pursuing alternative crisis stabilization options other than hospitalization.

Projected completion: quarterly training events

Actual completion: One training event was provided in April 1997 for all on-call staff; supervision and training were provided to specific staff. Plans to increase crisis stabilization beds began in FY 96-97 and were carried over into FY 97-98.

B. Develop a closer collaboration with the Aiken center to divert more substance abusers being seen in the Aiken Regional Medical Center Emergency Department into Aiken center's outpatient program.

Projected completion: December 31, 1996

Actual completion: The Acute Care Services Program director began meeting regularly with the clinical director to plan conjoint services and to improve the system for immediate referral of crisis consumers to the center. The center established a system to enable immediate services on a next day basis to enable the on-call crisis worker to refer consumers seen in crisis during off-hours.

C. Require management approval prior to on-call worker recommending hospitalization to ED physician.

Projected completion: August 1, 1996

Actual completion: This objective proved to be impractical and therefore was not fully implemented. However, on-call staff did consult regularly with the Acute Care Services Program director when diversion appeared to be appropriate. The current commitment system, which is physician-driven, makes it difficult for the center to assume accountability for admissions.

Performance: 166.6 persons per 100,000 were admitted to state hospital facilities in FY 96-97. This continues to be a major area of focus for the center. New administration at Aurora is interested in diversion and local hospitalization and management staff will continue talks regarding decreasing hospitalizations begun in FY 96-97.

* implement managed care principles into operations

Objectives:

A. Establish a process of utilization management for clinical services to assure provision of an appropriate level of quality clinical services to each client.

Projected completion: none noted

Actual completion: The Quality Assurance coordinator was on leave of absence for most of the fiscal year and then resigned her position shortly after returning from leave. Without this key staff, it was not possible to develop a formal utilization management process during FY 96-97. This activity has been undertaken by the new Quality Assurance coordinator for refinement in FY 97-98. Utilization Management activities were undertaken in individual programs, particularly Community Rehabilitation Services, with staff and the consulting psychiatrist beginning a review of all consumers' treatment to ensure the treatment provided is necessary and appropriate.

B. Maintain rapid access to clinical services:

1. New clients requesting services are seen for intake within three working days of initial request.

2. First treatment session occurs within 10 working days following intake.

3. Evening treatment sessions are readily available to those who need them in each of the center's three geographic areas.

Projected completion: Sept. 30, 1996

Actual completion: The center developed a policy regarding accessibility, which stated that new consumers would be seen for an intake within one day if emergent, three days if urgent or referred following a hospital discharge and ten days if needing a routine appointment. An intake appointment within three days was not achievable with the center's resources. It was felt the revised policy and goal were clinically appropriate. The center meets the policy expectations 80 percent of the time; the goal is a minimum of 95 percent.

Evening appointments were available in the three major geographical areas

throughout the fiscal year.

C. Clinical services will be cost effective.

1. A baseline of clinical subprogram costs will be established during FY 97-98.

2. Consumer satisfaction surveys for each clinical program will be conducted every six months.

3. An analysis will be made at least semiannually of combined data reflecting program costs, hospital admission data, and consumer satisfaction studies.

4. Increase utilization of brief therapy and group therapy services through Utilization Management.

Projected Completion: June 30, 1997

Actual Completion: Subprogram costs were not established during this fiscal year, largely due to the retirement and resignation of the center's key leaders, the resulting hiring of a new director, and the enormous amount of time spent on the move and CARF preparation. The new executive director and the administrator met with each program director to establish cost centers and prepare initial budgets for each cost center. The process was carried over into FY 97-98.

Two consumer satisfaction surveys were completed, with very positive results. Almost 90 percent of consumers responding stated they felt the services they were receiving were helpful and would recommend the center to others for services. The long-term leave of absence and subsequent resignation of the center's Quality Assurance coordinator and other changes noted above resulted in this objective's attainment being delayed until FY 97-98.

Performance: The managed care principles of accessibility and consumer satisfaction were successfully introduced into the center's operations. Other principles are being incorporated, with an expectation that the center will fully conform with major managed care principles by the end of FY 97-98.

* increase level of services for dually-diagnosed clients

Objectives:

A. In addition to maintaining the dually-diagnosed group in Aiken County, endeavor to establish a similar group in Barnwell County

Projected completion: Dec. 31, 1996

Actual Completion: Management and staff turnover resulted in this goal being addressed more from a systemic stance, with carryover into FY 97-98 for the establishment of services co-facilitated by the center and Axis I (Barnwell). Though the center did not meet this objective in terms of service provision, it is felt that the closer working relationship and identification of gaps in service as well as planning to fill those gaps was invaluable. Coprogramming is expected early in FY 97-98.

B. Develop a collaborative clinical service with the Aiken center for dually-diagnosed clients.

Projected completion: Dec. 31, 1996

Performance: Actual service levels were not increased during FY 96-97; however, more effective relationships were established with the alcohol/drug treatment agencies and planning initiated which will result in increased levels of service in FY 97-98.

* eliminate the center's budget deficit by June 1997

Objectives:

A. Clinical programs will be required to maintain a minimum unit productivity level of 50 percent.

Projected Completion: July 1, 1996

Actual Completion: An individual productivity expectation of 50 percent was set in the fall of 1996. In May 1997, the standard was changed to a minimum of 45 percent of paid time (@ 52 percent of available time). The center's overall productivity increased from 41 percent to 43 percent, with incremental increases each month. Staff who did not meet their productivity standard over time have been counseled and/or positions revised as needed. There is a clear message from management that the established productivity standard is achievable, that it is a bit low by industry standards and that it is expected to be met. Training on managing clinical paperwork so that it does not interfere with direct service has been provided to all interested staff.

B. A partial hiring freeze will remain in effect for FY 97-98.

Projected completion: June 60, 1997

Actual completion: Most vacant positions remained so throughout the fiscal year. However, an evaluation of need and income capacity resulted in plans to fill one Acute Care Services position in order to provide more effective crisis services, and to fill two case manager positions in Community Rehabilitation Services, to reduce very high caseloads and generate more income. The senior management team decided not to fill the associate director position during this fiscal year and to evaluate the need for this position over time.

Performance: The center ended FY 96-97 with a $192,177 deficit. This included a deficit of $142,515 carried over from FY 95-96. While this is a long way from the goal to eliminate the deficit, the good news is that the deficit for FY 96-97 was significantly less than the deficit for FY 95-96. Support of current operations and elimination of the deficit remain major goals for FY 97-98.

Anderson-Oconee-Pickens Mental Health Center
(Anderson, Oconee and Pickens counties)

The Anderson-Oconee-Pickens Mental Health Center started at its present location in 1969 with a $200,000 construction grant from the National Institute of Mental Health to erect a 7,100 sq. ft. building.

Since then, added to our facilities have been a 3,500 sq. ft. clinical building at the Anderson Center, and a 3,200 sq. ft. administrative building, a 4,600 sq. ft. clinic in Oconee County, and a 7,600 sq. ft. clinic in Pickens.

In addition, we have numerous program sites in the three counties including the 20,000 sq. ft. building at The Village.

Harris Hospital opened in our catchment area in 1985 providing excellent inpatient services for acute short-term needs.

When the center was first organized, our mission was defined as inpatient, outpatient, partial hospitalization, emergency and consultation and education. Our mission was to support special and local needs in conjunction with the overall DMH mission. We provided low-cost, readily available, comprehensive services to residents of three counties.

We have had many community support programs aimed at rehabilitation of clients. Family Preservation, Individual Living Skills, Rehabilitative Psychosocial Therapy, Restorative Independent Living Skills, Child and Adolescent (C&A) Day Treatment Program, School-Based Services, summer C&A Programs — all these have a part in restoring and improving the quality of life of our clients. Our Crisis Stabilization Program was shut down by a zoning problem, but is now revived with a new building under construction. Our C&A Program is also moving into new quarters when construction is completed.

Our responsibility includes screening all patients in our catchment area seeking admission to state facilities. We provide service to the public from 8:30 a.m. to 5 p.m. weekdays, with extended hours until 7 p.m. on Tuesdays. This includes walk-in assessments by qualified personnel with referral to a physician, if needed. Hospital consultation is provided by a mental health professional.

This includes 5 p.m. to 12:30 a.m. emergency room work at the Anderson Area Medical Center. Crisis Ministries provides trained after-hours service with our clinical back-up.

Our Outpatient Services are heavy, numbering about 4,900 cases. C&A Services are provided to over 1,200 clients experiencing emotional, behavioral and mental problems. Referrals are received from schools, pediatricians, family members and social service agencies.

In Anderson School District Two, we have one full-time staff person providing

school-based services to 50-65 students. One part-time counselor provided services to 50-65 adolescents at the Alternative School this past year. We also have a full-time counselor at the Dacusville School in Pickens County.

Our Consultation and Education Services include intensive care units, liaison to all state facilities and other agencies. Speakers are provided for community groups. Schools receive services and have been approached with plans to increase participation and effectiveness. Consultation is provided to personnel at jails, detention centers, court personnel and attorneys (when appropriate). About 75 percent of our clients receive services at the maximum deduction allowed.

Our current staff of 130 are inncreasingly well trained and receive educational opportunities through a revitalized Staff Development Program. Efforts are made on practically a weekly basis to recruit new persons to complement our employees.

Our caseloads are steadily increasing. In July 1992, our caseload was 3,437, with 731 of these being C&A clients. In June 1997, we had a caseload of 4,950 of whom 1,224 were children and youth.

While there have been some lean years financially in the last 10-12 years, we have gone from a budget of $1.5 million in 1987 to a $7.8 million budget in 1998.

The involvement of our board of directors, along with consumers and advocacy groups in provider leadership, has been a signal strength of our center. This activity has crystallized in an annual planning event that evaluates past performance and maps out future goals, objectives and direction.

Recently purchased computers and related teaching equipment enhance communication among staff at the center's various service locations and provide an important link with DMH administrative offices. The center seeks to utilize computers to make our services more effective and efficient by providing timely information to staff making clinical decisions.

The Anderson County Mental Health Association is coordinating the construction of 18 apartments for the chronically mentally ill. The center will support this effort by providing case managers, job coaches and crisis intervention services.

The center has been preparing for CARF accreditation since last August. Accreditation survey dates have been set for September 24, 25 and 26 of this year.

Goals for FY 97-98 are to:

* open non-medical Crisis Stabilization Unit currently under construction;

* open Child, Adolescent and Their Families services in a facility currently under construction;

* expand Oconee Mental Health Clinic to meet additional space needs;

* employ an additional psychiatrist;

* hire three geriatric specialists to expand services to the elderly;

* continue to increase school-based services via collaboration with school districts in the catchment area;

* work with Anderson County Mental Health Association to place 18 chronically mentally ill persons in the new apartment complex;

* complete TLC III objectives by having moved 10 persons from state hospital facilities to the community;

* continue compliance with CARF standards as outlined in 1997 Standards Manual;

* continue strengthening Crisis Service Team by hiring full-time crisis staff;

* continue study of admissions to center in order to ensure services for targeted populations;

* increase number of licensed clinical staff by 100 percent;

* explore Employee Assistance marketing in the area;

* employ a consumer advocate for families of mentally ill persons;

* increase public awareness and knowledge of center's services; and

* employ an information resource coordinator.

Beckman Center for Mental Health Services
(Abbeville, Edgefield, Greenwood, Laurens, McCormick, Newberry and Saluda counties)

Possibly the single most significant decision ever affecting the future of The Beckman Center for Mental Health Services occurred during FY 96-97. The commitment to this decision and managing for a successful outcome have influenced every facet of the organization during FY 96-97.

The center is working to achieve its first national accreditation through the Commission on Accreditation of Rehabilitation Facilities (CARF), with the survey requested for September 1997.

Many of the goals currently in progress have been predicated by the 1996 CARF Standards under which accreditation review will be measured.

In July 1996, a CARF coordinator was named to provide direction during accreditation preparation. Initial efforts included becoming thoroughly familiar with 1996 CARF Accreditation Standards under which the center expects to be surveyed.

A Quality Improvement Team (QIT) was formed with the mission to guide CARF activities. Each of the five applicable sections of the CARF Standards Manual was assigned staff responsibility.

With the CARF theme ever present during daily center operations, the center continued in the seven counties served to actively promote and deliver mental health services according to its mission statement.

Beckman Center is responsible for an area population of approximately 228,272 persons or approximately 6 percent of the state's population.

To enhance the gate-keeping role inherent in upholding the mission statement, the center added two of the three proposed triage positions for the larger clinics. Greenwood and Newberry added triage staff in September 1996. Managerial changes in the Laurens MHC postponed development of triage, however this position will be filled during FY 97-98.

Triage staff and clinic directors became primarily responsible for client screening, admission and/or referral.

The increased efforts to better monitor admission appropriateness and to promote a more solution based clinical approach for the non-seriously mentally ill person served, resulted in a 4 percent decrease in contacts down from 94,241 to 90,071.

Again, attention to the mission and better community education concerning appropriateness of referrals are credited with a decrease in the total number of persons served from 7,585 to 4,768, a decline of 37 percent. Current available data does not reflect the persons screened but not admitted to our service.

A goal for FY 97-98 will be the development of a more measurable system to monitor persons screened but not admitted and/or who are referred to more appropriate service providers.

As of July 1997, the center shows 2,800 active cases--45 percent male, 55 percent female; 53 percent white, 46 percent black; 28 percent age birth to 17 years, 66 percent age 18 to 64 years and 07 percent age 65 years and older.

This corresponds equitably with state statistics which show 48 percent male, 52 percent female; 69 percent white, 32 percent black; 26 percent age birth to 17 years, 62 percent age 18 to 64 years and 11 percent age 65 years and older.

A major goal set and completed during FY 96-97 was the complete evaluation of existing policies and procedures and the development of needed additions. Incorporated into this process was the exploration of DMH Directives and their timeliness and applicability.

One of the most successful goal completions of FY 96-97 was the development of a center Safety Program — a new emphasis for staff.

Twenty-five policies and procedures were developed or refined by management and approved for implementation in April 1997. Five safety officers were designated at the administrative level. Eight local safety officers were appointed for two-year terms to coordinate local safety activities and provide membership on the center's newly created Safety Committee, which began meeting in February 1997. Committee members provided input into policy and procedure creation.

Fire, natural disaster and violent behavior drills were begun in May 1997 and

documented using a monthly safety report form developed by the center. Internal safety inspections are also documented. Three staff were trained as CPR instructors, and all employees were provided CPR training during the summer months. Ongoing training will insure instruction for new employees.

Continuing a FY 95-96 commitment to excellence, the center wrote its first Total Quality Management Initiative and was approved in July 1997 by the S.C. Budget and Control Board for $11,000.00 funding for implementation.

The proposal contained three phases. First, all employees of the center would receive introductory training in Total Quality Management concepts. This was accomplished during September 1996 through contract with Piedmont Technical College and its Center for Performance Excellence. Phase Two provided Management Team members eight selected modules of Zenger-Miller FrontLine Leadership Training. This was accomplished between October and November. The third phase provided for the selection, training and certification of six staff as Zenger-Miller Trainers. Individuals were successfully certified in October.

The on-going result was and will be continued Zenger-Miller training available to staff, especially supervisors. The first eight-week experience was completed between April and June 1997.

Concurrent with the TQM Initiative, the center focused on team building through agreement with John de la Howe School for ropes course experience. During September, 10 functional teams participated in one-day sessions designed to strengthen trust and build group commitment. Follow-up survey of the 111 staff participating indicated that 93 percent of the staff found the time well spent.

In embracing concepts of quality and beginning the internal Total Quality Initiative, the employee has become a valued internal customer.

To help management at all levels obtain a better picture of working conditions and social climate within our organization, a 1995 comprehensive staff survey was repeated in January 1997.

The center Employee Survey used 51 questions with response requested on an Agree/Disagree continuum. Responses were aggregated by grouping 1-3 on the negative side and 4-6 as positive.

While the initial survey showed a higher degree of positive over negative responses in the majority of questions, our goal was to increase the percentage of positive responses to each question by 5 percent. The 1997 response showed a gain in the percentage of positives on 46 of the 51 questions. Of the 46, our +5 percent goal or better was achieved on 21 items. An additional three showed a 4+ percent gain; three reflected a 3+ percent gain; and seven had a 2+ percent gain.

The largest single gain was to the question, "If you had it to do over and knowing

what you know now, would you still decide to come to work for the Beckman Center?" The gain was 27 percent.

By July 1996, our goal to relocate the Saluda and Edgefield Mental Health Clinics to larger more accessible space had been achieved. Both locations allowed for children's services and waiting areas to be separated from the adult.

Administration assumed additional space in order to wrap all regional program services back into a centralized location and to provide needed warehouse space for procurement and distribution.

Due to the 3,000+ square mile territory covered, the center provides internal courier service three times per week. This permits more centralized buying to enhance the sound fiscal management, which is an on-going goal. Improving communications among the 22 service delivery sites is an added courier benefit.

Two goals impacting physical structure during FY 97-98 will be the completion of a thorough accessibility study to be conducted during July and August 1997 of all buildings owned, rented or leased by the center. Results of this study will be addressed prior to the CARF Survey through a report to the center board of directors and development of an annual Accessibility Plan for their approval. During the remainder of the fiscal year, the center will strive to eliminate difficulties identified.

Expanded computer technology continues to enable efficient and effective service delivery. During FY 96-97, the center met its goal to upgrade the Novell system to the 4.1 version. Stand-alone computers were installed for all clinic and program directors during the spring. The center continues toward the goal of providing file servers for clinic locations in order to eventually connect sites through e-mail.

Development of housing alternatives was identified as a FY 96-97 goal and will be continued into FY 97-98. Staff have nurtured community linkages in order to facilitate needed housing as a case management function. The further development of a Housing Program will be continued by the Community Rehabilitation Program director as he more fully assumes the duties of this position. Though this vacancy was filled during FY 96-97, clubhouse vacancies have received necessary priority of his time. Focus will resume during the months ahead.

As previously stated, a successful CARF Accreditation survey outcome is the number one goal during FY 97-98. The center will be seeking accreditation in Mental Health Outpatient Programs, Mental Health Outpatient Case Management and in Community Rehabilitation Programs. As we move toward a more rehabilitative philosophy and outcome based evaluation, program evolution will occur.

The development and implementation of meaningful outcome measurements will also be a top priority during the next fiscal year.

Outcome measures beginning July 1 will include (1) capturing baseline

satisfaction/efficiency data using an initial questionnaire at the time of assessment, (2) quarterly satisfaction/efficiency/effectiveness measurement through survey collection on the first working day of each quarter and (3) 30-day discharge follow-up using prepaid postcards for return mail.

In addition, the center will conduct a community survey as a two-year follow-up measurement. Annual employee satisfaction / attitude reassessment will occur. In addition, the center will track adverse incident reports to measure the timely, appropriate and preventative aspect of service. A goal of the Quality Improvement Team is the development of appropriate resulting action based upon results identified.

Beginning first quarter FY 97-98, the center will provide expanded materials through new brochure development for center, adult outpatient, children's services, case management and community rehabilitation. Orientation of persons served will begin with a newly developed orientation manual provided to all consumers admitted to treatment programs.

The Employment Program is expected to expand with planning underway to hire four new job coaches to serve Greenwood, Laurens, Newberry and Saluda-Edgefield.

Another area of expansion anticipated is the further collocation of C&A services with a school-based program under development in Laurens, a position expected with John de la Howe School in McCormick and a state pilot position with the Department of Juvenile Justice female residential facility in Greenwood.

The management of 24-hour emergency services in such a large and diverse catchment area continues to present a challenge. With five hospitals to cover and law enforcement needs to consider, the center continues to explore timely and efficient response patterns. Further refinement of this process continues as a FY 97-98 goal.

The Beckman Center for Mental Health Services looks toward the next 12 months in anticipation of becoming a nationally accredited behavioral health provider. Through accreditation and attention to excellence, the center strives to more satisfactorily, efficiently and effectively fulfill its mission.

Berkeley Community Mental Health Center
(Berkeley County)

For FY 96-97, the board of directors and the staff of the Berkeley Community Mental Health Center made a commitment to two major goals:

* to improve the quality of care by gaining input from consumers, families, staff and other service providers/partners; and

* to make the changes necessary to end the fiscal year with a balanced budget.

With a projected budget deficit and with over 80 percent of the available resources budgeted in personnel, the decision was made to freeze vacant clinical and adminis-

trative positions. As anticipated, the clinical staff were expected to be responsible for additional clients and their families. Failure to employ administrative staff made it impossible for all functions to have the priority that was requested.

In an attempt to generate additional revenue, supervisors were re-assigned to clinical positions with the responsibility to provide direct services. Because funds were not available, staff were unable to receive financial support to pay for on-going training.

The total number of employees was reduced to approximately 50. These employees worked together to serve their consumers and to improve the service delivery system.

Consumers, families, staff and community providers/partners were surveyed to gain input about needed improvements. The major need identified was education about mental illness, how to achieve and maintain a healthy lifestyle, laws pertaining to mental health treatment, and the DMH mission and the Berkeley Community Mental Health Center. In response to the findings of the surveys, various community-based educational activities will be on-going.

The staff surveys revealed that while employees had major clinical and administrative responsibilities, they wanted to be more involved in the decision making process. In response to this request, the management team was expanded and was re-named the Quality Improvement Team. Additional committees are currently identifying solutions to organizational and operational issues.

Because of the proposed budget deficit, capital improvement to the property, the upgrade of computer equipment and the purchase of vehicles to transport consumers were delayed.

After a review of center operations, the DMH office of internal audit documented the absence of the necessary infrastructure and staff to meet the demands of the consumers, the community and DMH. It was recommended that a plan be implemented to increase the available resources.

Beginning July 1997, the center will receive additional revenue which will raise the level of per capita funding. These funds will be used to employ additional staff and to address major equipment needs.

Two major accomplishments for FY 96-97 were:

* the center improved the quality of care provided to consumers by responding to input from consumers, families, staff and other service providers/partners; and

* the center ended the fiscal year with a balanced budget and funds available to purchase vehicles to transport consumers.

The year was challenging and rewarding for the board of directors and the employees of the Berkeley Community Mental Health Center.

Major goals for FY 97-98 are to:

* make organizational and programmatic changes that support individualized goal-focused treatment, continuity of care, consumer involvement and cultural diversity;

* determine costs of center programs;

* develop outcome measures which will provide data necessary to measure effectiveness of all center programs;

* make organizational and programmatic changes as required to meet the needs of our consumers based on cost studies and outcome measures;

* continue to seek input from consumers, the staff, other service providers/partners and the community related to their satisfaction with the center as a treatment facility and a workplace; and

* provide a work environment that inspires and promotes innovation and creativity and supports educational opportunities which will prepare employees for the work that they do.

Catawba Community Mental Health Center
(York, Chester and Lancaster counties)

The Catawba Community Mental Health Center provides services for an estimated 219,000 residents in Chester, Lancaster and York counties.

The comprehensive center has an administrative office in Rock Hill and clinical offices located in Chester, Lancaster and Rock Hill.

The center currently employs 104 permanent staff and four temporary staff. Currently, there are seven permanent staff positions vacant. We have developed 11 new positions that we are advertising.

More than 2,650 open cases are served and maintained with the current staff and a budget of $6,018,104. Sources of budget are 39 percent state, 8 percent block grants, 2 percent county, 48 percent Medicaid revenue and other fees, and 3 percent other grants.

Center-wide psychiatric admissions are up by about 6 percent. Strategies include filling the seven FTI permanent positions, and 11 new staff positions should help in reducing adult admission rates by at least 15-20 percent.

Alcohol and other drug admission rates have been reduced by 10 percent and will be reduced even more when the staff vacancies are filled.

Intensive case management teams have now been developed in all three counties and are working just fine. With the addition of new staff positions and the current vacant positions being filled, intensive case management teams will be even stronger.

The housing grants that Catawba wrote and submitted were approved and funded

for Chester and Lancaster counties.

A 16-unit apartment community is moving forward in Chester County, and the TLC project for Lancaster County has been approved and is moving forward.

We have increased physician coverage in all three counties and have employed one full-time child and adolescent psychiatrist.

We implemented the Proviso in all three counties, which is now called the Inter-Agency System of Care for Emotionally Disturbed Children. The Family Preservation Programs of Chester and York counties continue to be examples of excellence. Funds are still being sought to develop a Family Preservation Program in Lancaster County.

The need for services for foster families continues to increase, and we continue to have at least one clinician in each county of our catchment area that provides services to foster families.

We have at least one school-based clinician in each county of our catchment area. Chester County has three full-time school-based clinicians and four student interns from Benedict College who will also work in the schools.

York County has one school-based clinician on board, and funds have been appropriated for four additional masters level clinicians.

One bachelors level student intern and four masters level student interns will be serving as school-based clinicians as soon as Oct. 1, 1997. Lancaster County will have one new school-based clinician.

As an alternative to a planned school curriculum, York County offered the Cities in Schools Program. Chester County now has a similar program in place. There is no similar program offered in Lancaster County at this time.

The written plans that were developed by physicians and clinicians have increased and continue to increase the efficiency and effectiveness of our clinical programs.

All of our county offices are open at least until 7 p.m. four days per week, with one staying open later.

Nursing coverage has been increased, as we have at least one full time nurse in each county facility.

We established and improved relationships with all agencies that serve children and adolescents in our catchment area. We have evaluated children and adolescent summer camp programs and have made and implemented positive changes.

The public education and speaking program that the center developed and implemented continues to be well received throughout the area.

Goals for FY 97-98 are as follows:

* The center will position itself as a key player in the behavioral health system of care in our communities.

* Consumers will participate in planning, managing and evaluating programs.

* In the adult population, emphasis will be placed on meeting the needs of those who are seriously and persistently mentally ill.

* Child and adolescent services will be increased, with a priority placed on service provision in the natural setting, such as home and school.

* Services will be delivered to assure quality in the least intrusive and most cost effective manner, with an emphasis on consumer involvement in planning outcome oriented interventions at the most clinically appropriate level for the individual.

Charleston/Dorchester Community Mental Health Center
(Charleston and Dorchester counties)

During FY 96-97, the Charleston/Dorchester Community Mental Health Center experienced an increase in its caseload by 31 percent from 3,610 to 3,723.

A concurrent trend was a leveling off of Medicaid fee-for-service income and a consequential strain on center resources to provide adequate services.

Priority groups being provided services were adults with serious and persistent mental illness, children with serious emotional disturbances and persons with psychiatric emergencies and short-term follow-up of these persons.

The center again led the state with the lowest rate of admissions to central psychiatric hospitals. Much of this success is attributable to the ability to hospitalize persons locally, especially at the Medical University of South Carolina.

The center ended the year with a surplus of $140,000 in a budget which totaled $13,585,000. Its 253 full-time staff were scattered over 47 sites in two counties including 30 public schools. A total of 5,744 different individuals received services.

Emphases in the administrative area included enhancement of computer operations and development of management reports for all levels of supervisors.

A nine-year effort to purchase property for a facility in Charleston collapsed in the face of persistent community opposition.

A full-time volunteer coordinator significantly enhanced the use of volunteers throughout the center.

The center's Magnolia House day treatment program was recognized as the outstanding psycho-rehabilitative program in the state.

Efforts to improve services included an active continuing education program and an externally-contracted clinical supervisor to assist counselors in getting independently licensed.

The center continued its many collaborative efforts with MUSC, including the

Mobile Crisis Program, residency training programs, several research projects, joint hiring of physicians, and the use of inpatient beds at MUSC for adults and children.

Very significant efforts went into preparing both clinical and administrative operations for accreditation review scheduled for September FY 97-98.

Goals for FY 97-98 are to:

* attain CARF accreditation;

* complete extending the computer LAN system into most of the center sites;

* identify a new site for purchase and construction of a new facility; and

* restructure Charleston Adult Short-Term Outpatient services into a more efficient and accessible program and create an Adult Intake Service.

Coastal Empire Community Mental Health Center
(Allendale, Beaufort, Colleton, Hampton and Jasper counties)

Coastal Empire Community Mental Health Center continued to expand existing programs and develop new ones. The center currently employs 97 permanent staff and 11 part time staff. The active caseload as of June 30, 1997, was 1,747.

The center continued it efforts to increase effectiveness and efficiency and was able to increase the overall productivity (average daily service hours) by 2 percent over FY 96-97.

Due to a change in the Medicaid rate of reimbursement and other factors, the center's Medicaid revenues decreased by 20 percent when compared to FY 95-96. In order to offset this, increased efforts were made to increase our self-pay collection, which resulted in an increase of 13 percent compared to FY 95-96.

Additionally, efforts were made to increase the percentage of clients paying a negotiated amount for their medication. The center was able to increase these payments by 28 percent.

Beginning this past year, we instituted a process of developing area/program budgets to allow more local decision making and provide staff with monthly information about the center and area/program financial status.

The center made significant progress toward its annual plan goals for FY 96-97.

The child, adolescent, and family staff's goal to increase, improve and maintain specialized services to severely emotionally disturbed children, adolescents, and their families was accomplished by:

* C&A staff continuing to work closely with other agencies and schools within the five counties;

* in Beaufort County, the C&A staff continued its involvement with the Collaboration of Services for Youth (COSY) project; this group screens all children or adolescents thought to need therapeutic residential care and attempts to develop an

alternative non-residential community treatment plan; its success has led DMH and Human Services Finance and COSY to assist in setting up interagency teams in other counties in our area;

* the center recognized a problem of waiting lists for C&A services in the Beaufort and Jasper clinics; by adding staff in both counties and by increased utilization of group therapy and multifamily groups, the waiting lists were eliminated in both counties;

* the C&A program was reorganized to improve supervision of C&A staff in the five counties. The C&A director now provides direct supervision to most C&A staff with additional consultation provided by the child psychiatrist at least twice per month or more often as needed.

The center continued to expand and increase services to persons with severe and persistent mental illness in the following ways:

* initiating a Clinical Rehabilitation Team in the Beaufort Clinic; as part of a statewide initiative, the team members and supervisors received on-site consultation and developed a system that would improve services by utilizing the team model of case management;

* case management services were expanded in Allendale, and there was an increased utilization of Rehabilitative Psychosocial Therapy (RPT); the building formerly used as the clinic is now being used three days per week as an RPT site; and

* although the center was unable to meet its goal of reducing admissions, efforts to prevent admissions to psychiatric hospitalization continued; this resulted in the center having the fourth lowest admission rate in the state among the 17 community mental health centers.

Staff development, training and education were a priority for the center during this past year. The center developed a comprehensive training plan and made the decision to provide more on-site training for staff. This was accomplished by bringing outside trainers from both the private sector and from within the state system.

Comprehensive training was providing on site in the following areas: Solution Focused Group Therapy; Psychiatric Diagnosis, Treatment, and Recovery for the SMI; Suicide Assessment and Intervention; and Brief Psychotherapy.

Relationships with colleges and universities were enhanced by providing internships for social work and training opportunities for nursing students at various sites within the center.

The center devoted considerable effort toward preparing to obtain accreditation and completed its application for CARF. As part of that effort, program descriptions and admission criteria for each program were reviewed and further developed. The orientation for new consumers was enhanced with an orientation packet to be given

during the initial intake process, and a more formal orientation process was initiated.

The center reinstituted its client satisfaction survey and obtained responses from 257 consumers. This provided valuable feedback for quality improvement and program planning.

Key goals for FY 97-98 are to:

* increase community awareness of center services;
* strengthen and further develop a volunteer program;
* complete the CARF accreditation requirements and obtain accreditation;
* strengthen and further develop the center's relationships with the local physicians and local hospitals;
* expand the School Based Services into one additional county;
* establish a consumer/community advisory board;
* continue to work with the local Mental Health Association to expand housing availability for the center's seriously mentally consumers;
* determine the cost of center programs and services;
* evaluate the effectiveness of center programs and services;
* increase center productivity; and
* increase center generated revenues.

Columbia Area Mental Health Center
(Richland and Fairfield counties)

FY 96-97 was a year of recovery and preparation. Following a very difficult year in which the center was preoccupied with concerns over budget, FY 96-97 was a year of implementing modest changes necessary to provide basic services to clients. It was also a year of preparing for accreditation and planning for long term, basic changes in the way the center serves the public need.

The center worked closely with a community consortium to develop the Children's Center of South Carolina. This "one-stop shop" will provide residential placements, evaluation, treatment and case management for all children removed from their homes by the Department of Social Services or law enforcement.

The center also filled a position partly funded through the DHEC sponsored BabyNet Program. This clinician provides evaluation and treatment to families of children zero to three years old with physical and/or mental disabilities.

The center increased services to children in schools by 33 percent. This makes treatment available to children and families in places that are more convenient.

We added staff to basic clinic services during the year. Two case managers and a support staff position were added in our Central Adult Clinics, and we added two case managers in our satellite clinics.

The center's Central Adult Clinic also implemented a series of changes in how it serves clients. Treatment staff and the medical director are reviewing all new clients referred to its program.

The combination of staffing, addition of staff and careful review of existing cases resulted in a 30 percent reduction in Central Adult Clinics caseloads. The primary result of this reduction is to allow staff to provide more individualized care to clients.

The center added a registered nurse to our Nursing Service initiative, allowing this innovative service to increase over 100 percent the monitoring of clients on neuroleptic medication. The nursing staff developed new forms, which provide more detailed information on the effectiveness of treatment and also provide a way for nurses to monitor and report on clients' general health status. The forms are stored in a specific section of each client's medical record, providing physicians and case management staff with easy access to this key clinical information.

One of our major goals for FY 96-97 was to evaluate the ability of the center and DMH to continue to support the costly, but effective, Marshall Street Crisis Stabilization Facility. Census continued to be a problem during this year.

As originally projected, this center could not continuously fill 16 beds. Lack of full census played some role in the ability to secure fee for service funding. However, the program serves a large number of individuals without ability to pay, and filling beds will not change this problematic budgetary issue.

At DMH's request, staff evaluated other operations that were advertised as similar to Marshall Street to see if there was a way to reduce expenditures. Each of the programs reviewed differed in substantial ways from our program, making their designs inappropriate to our clinical operation.

Following this review, the center's board directed center management to carefully evaluate our options. A day-long retreat, participated in by several board members, produced a series of proposals.

This center recommended regionalization of the program to serve individuals from more than Richland and Fairfield counties and proposed to develop new agreements which would make referrals beyond the center and Richland Memorial Hospital's Emergency Room easier.

The center also requested that DMH become the payer for Marshall Street services rendered to individuals who did not have other resources.

The center proposed that DMH and the center develop a utilization review and management protocol to ensure that individuals referred to the program meet criteria for program participation and payment.

Following intense negotiations, DMH initially declined to accept these proposals, as written.

The board ordered the center to seek permission from DMH to close the program in the absence of adequate funding. DMH reviewed its options, realized that substantial increases in hospitalizations would occur should Marshall Street close and decided to guarantee funding contingent upon regionalization of the program.

The center, the board and DMH all hope that this thorough review of options will place this unique program on stable ground well into the future.

The center has made substantial progress in a number of other areas this year. We have spent considerable time and energy developing programs, policies and practices in preparation for national accreditation through the Commission on Accreditation of Rehabilitation Facilities (CARF).

Staff have worked hard to document what we do, change to better reflect our rehabilitative intent, and to collect information to prove that we provide good outcomes for individuals we serve and to improve what we do to serve them better in the future.

The center's internal planning, monitoring and review processes have undergone substantial change in preparation for collection and measurement of clinical outcomes. Our internal management reporting systems have become more sophisticated.

The center has implemented a very formal operational planning process and produced a substantial internal planning document. Our intent is to increase our rational planning process in order to help us prioritize competing goals when there are very limited resources to accomplish these goals.

In addition to the goals we made for this year, we were able to accomplish a number of other good things.

We provided clinical and administrative support staff with monthly training opportunities designed to improve our customer relations.

We consolidated Central Adult Clinics programs unto a single facility, reducing confusion for clients and facilitating better coordination of services. Center administration moved out of the clinical programming area to another leased facility.

The S.C. Mental Health Commission provided $100,000 to fund a request by Columbia Area to complete a long range facilities master plan. An architectural firm was hired and will present the master plan as well as preliminary drawings for the first phase of construction.

The board and staff negotiated an agreement with Richland Memorial Hospital to buy us out of our long term ground lease. This will go a long way toward funding the first phase of construction for a new building that is owned by the center. This construction will ultimately reduce our lease costs and free resources to allocate to client care. The first phase is scheduled for completion by January 2000.

People served in mental health centers in South Carolina frequently experience multiple problems— mental illness as well as substance abuse. Some of these individuals, in fact, do not have a mental illness at all, but are served by us as if they are mentally ill. This occurs because it is difficult to separate the symptoms of substance abuse from the symptoms of mental illness. Unless staff have specialized training and clients receive a thorough evaluation, people can be incorrectly treated.

This center has carefully evaluated our resources, evaluation and treatment protocols. Following this evaluation, we have provided staff with some specialized training and formed agreements with the local alcohol and drug commission to participate with us in a joint intake process. This will allow clients presenting to the center who may have some mixture of mental illness and substance abuse problems to receive correct evaluation and diagnosis and to get the treatment they need.

The Carter Street Residential Program will soon be able to increase capacity from 52 to 60 residents due to DMH funding and construction of an office building for program staff who formerly occupied several apartments.

DMH matching dollars helped secure funding for the purchase and renovation of a large apartment complex in Columbia. The complex will be owned and operated by the Volunteers of America. Five of these apartments will be for clients (including families) connected to the center.

Further, the center was awarded a TLC III grant and will contract with the Mental Health Association of SC to operate an intensive residential program for 12 residents.

The Annual Employment Celebration recognized over 80 clients who have been disabled by their mental illnesses for going back to work at some level in the past year. Also, our Employment Program became a member of the Greater Columbia Chamber of Commerce in the hope that contacts made there will lead to more job opportunities for our clients.

The three clubhouse programs, Rosewood, New Horizons and Independence House, all had well-attended family days. These days provide clubhouse members and families an opportunity to share a special time with each other, build a greater sense of community among those affected by serious and persistent mental illnesses and to increase family members' understanding of and participation in our joint efforts at reducing the effects of mental illness. These activities are highly valued by staff, clients and families and have now become part of the programs' annual special program activities schedule.

Center staff and management participated in a formal planning process during the year and developed priorities for program initiatives for FY 97-98. The list includes 68 separate items.

The center is currently projecting a budget deficit again this year, and this could

severely limit our ability to achieve many of these goals. However, several will be pursued:

* we will apply for CARF accreditation during the year;

* we will request funding for an additional physician to adequately serve the clients who depend on us for medication regulation;

* we will actively participate in the DMH strategic planning and outcomes measurement systems;

* we will expand school-based services and plan for improved services to adolescents as they become adults;

* we plan to refill vacant positions in our family preservation programs;

* we expect that the Carter Street and Independence House renovations will be complete so that we can ensure a safe environment for residents of these DMH-owned apartments and for clubhouse members;

* we will implement a contract with the Mental Health Association of S.C. for a high management group home and supported apartment living for 12 long-term S.C. State Hospital patients being discharged to the community;

* we will regionalize our Marshall Street Crisis Stabilization Facility, offering this unique level of care to residents of some non-center catchment areas; and

* we will improve our evaluation and services to individuals with both mental illness and substance abuse services through a pilot clinic program.

We will face multiple challenges during the year as we attempt to make long-range plans necessary to deal with still unclear forces in the community. These forces involve possible changes in funding mechanisms for community mental health centers, state or federal level performance based contracting, regionalization and other structural changes in DMH. It will be a challenging and difficult year.

Greenville Mental Health Center
(North Greenville County)

The Greenville Mental Health Center provides services to the residents of the city of Greenville and the northern part of Greenville County. In FY 96-97, the center continued its commitment to providing comprehensive services to the citizens of our catchment area with an emphasis on the seriously mentally ill and children, adolescents and their families.

The number of open cases continued to hover around 3,000 with 3,180 cases open at the end of the fiscal year. Individual contacts, a reflection of the total work accomplished, averaged 6,444 per month with 77,331 contacts this fiscal year.

The number of employees fluctuated from 84 in the beginning of the fiscal year to 88 at the end of the year. Of those, 63 were clinical positions.

In keeping with the center's nine management principles, we achieved progress on our goals consistent with our mission statement and its values. The center's management principles are to:

* expand service areas and diversify services;
* improve access to center programs;
* integrate a model of access to total health care;
* provide primary and secondary prevention programs;
* provide "consumer" focus to service delivery;
* provide education and training opportunities;
* be financially responsible;
* manage risk; and
* evaluate:
    a. Clinical programs;
    b. Non-clinical programs;
    C. Financial status;
    d. Consumer input/satisfaction.

The Consumer Affairs coordinator continues her active role by distributing family and consumer satisfaction surveys (in conjunction with our Quality Assurance coordinator), leading a monthly SHARE Group and gathering consumer input used to improve center services and programs. We have also implemented a Consumer Advisory Board that meets on a monthly basis. This advisory board is composed of consumers from all program areas.

The center has developed program descriptions, admission criteria, outcome measures and brochures for each center program. This information is included in handbooks that were distributed to local community agencies. Consumers receive orientation manuals to enhance access to services available at the center.

Outcome measures developed center wide include a Patient Severity Rating Scale (included in the Initial Assessment Form and updated every six months) and rating progress on client goals on a quarterly basis (on the client's Individual Treatment Plan). Specific outcome measures will be developed for each program/cost center during FY 97-98.

We have continued to refine our walk-in system of appointments. To help our patients negotiate the intake process and assist in orientation, we have assigned a staff member to greet and help walk patients through our system and provide answers to questions in a courteous fashion. We have revised our follow-up procedures to encourage staff to consistently follow-up with "no-shows" to improve continuity of care and have implemented a telephone follow-up survey for closed cases to get input on progress made by our consumers and satisfaction with the

treatment they received.

The center started the year with a carry-over deficit of $103,000. We developed fiscal strategies to reduce the deficit, which included increasing patient contacts, increased productivity of center staff, close monitoring of expenses and diversifying our financial base by developing revenue producing contracts.

We have developed the following contracts: Greenville County Law Enforcement Center (LEC) — to provide psychiatric evaluations/services to adult and juvenile inmates from all of Greenville County; Greenville Department of Health and Environmental Control (Health Department) — to provide counseling and case management services to HIV clients; and Slater-Marietta Health and Human Services (a rural health care clinic) — to provide assessments and counseling to children, adults and senior adults in the rural northern section of the catchment area.

We eliminated our deficit by the end of the fiscal year and anticipate another carry-over surplus this year of approximately $200,000, which will be earmarked for further development of after-hours services and hospital diversion programs.

The center continued its emphasis on training and education. Approximately 80 medical students, residents, psychology interns, social work interns, medical records interns and nursing students rotated through the center during the year.

We are extremely proud of Terry Paden, who received statewide recognition as the Outstanding SCDMH Employee. This is the second time in the past four years that a center employee has been selected for this honor.

We have made considerable progress in meeting our goals for FY 96-97:

* continue to evaluate our treatment programs with effort to ensure need/service match in our service delivery by the following:

(a) redevelop CRS services from the standpoint of cross-training, team approach and outcome measures;

Status — In October 1996, the center began participating in the Clinical Rehabilitation Team (CRT) concept. This model emphasizes cross-training, a team approach in working with the chronically mentally ill and a statewide outcome measure research project. Outcomes include client symptom ratings, evaluating clients' role performance, consumer satisfaction, family satisfaction and staff satisfaction with their new job roles. Baseline data has been collected as well as two quarterly updates of outcome data for this project.

(b) evaluate C&A programs by use of outcome measures;

Status — The center implemented outcome measures in its Children's Day Treatment Program, which reveals a significant increase in self-esteem and family-esteem in children involved in this program. Outcome measures are currently being developed in all center programs.

(c) attempt to increase prevention efforts, particularly in C&A, looking at linkages to behaviorally-disturbed children and long-term outcomes;

Status — The center increased its involvement in health fairs and other prevention programs and has developed linkages with other agencies and programs that serve behaviorally-disturbed children—DSS, DJJ, Babynet, the school system, etc.

(d) explore alternative programs and services to the elderly;

Status — The center has explored services to the elderly in nursing homes and congregate housing programs but has not been able to implement these programs due to Medicare funding limitations. We will continue to explore other options.

* formalize linkages with primary health care providers through contracts/MOA's/policy development;

Status — The center has established contracts with AIDS Upstate (a support group and case management), the Greenville County Health Department(counseling and case management for HIV clients), Slater-Marietta Health and Human Services (psychiatric services for all age groups), the Detention Center (psychiatric evaluations/services for inmates) and the Greenville Community Health Center (joint referrals, case management and training).

* develop a dual-diagnosis manual and redevelop a memorandum of agreement with DAODAS;

Status — A dual-diagnosis manual was developed and distributed to all staff, and a new MOA was developed with DAODAS.

* develop Acute Care Services to reflect consumer-friendly access, some aspects of utilization management, and group and short-term treatment modalities;

Status — The center developed six new acute care groups in addition to short-term treatment modalities. We also initiated an intake coordinator to improve consumer-friendly access to the intake system.

* further develop case management to include all aspects of our center and utilize some consumer involvement in the process;

Status — Case management is available to all program areas. We have increased case management services to adults by 61 percent and children by 159 percent.

* ensure access to transportation by Medicaid and non-Medicaid populations;

Status — We have increased the number of Medicaid transportation riders from an average of 70 per month to over 380 riders per month. Case managers are also working with non-Medicaid populations to access transportation services.

* pursue accreditation by nationally recognized accreditation body.

Status — The center applied for CARF accreditation in April 1997 and have a scheduled survey in September 1997.

Goals for FY 97-98 are to:

* complete CARF accreditation;

* further refine cost centers and computer reports;

* develop outcome measures for all cost center programs;

* implement options for after-hours services including hospitalization alternatives;

* upgrade computer networking system and implement scheduling system at C&A services; and

* investigate the possibilities of a combined effort with local agencies to establish a forensic services center to include pre-booking evaluations and treatment, jail deterrents, officer training and local competency exams — based on a model from Orange County, Florida.

Lexington County Community Mental Health Center
(Lexington County)

The Lexington County Community Mental Health Center continued to expand service delivery during FY 96-97 through the development and implementation of new programs and partnerships with community and governmental human service agencies and practitioners.

The following goals were met during FY 96-97:

* The clinical/financial triage system was implemented center wide.

* Partnerships with local medical facilities and home health agencies were completed through the execution of Memoranda of Agreements with Lexington Medical Center and Tri-County Home Health Services.

* The center applied for accreditation from the Joint Commission on Accreditation of Health Organizations (JCAHO).

* Construction began on the Children, Adolescents and Their Families Services Building with an estimated completion date of March 1998. The Acute Care/Administrative Services Building is in the bid process.

* Services to the Lexington County Detention Center were increased to seven days a week.

* Several school districts are still pursuing with us the possibility of a conjoint school based day treatment program, pending available funding.

* School Based services were added to seven more schools in the county.

* Initial contacts have been made with nursing homes in the area to develop contracts to provide mental health services for their residents.

Goals for FY 97-98 are to:

* continue to explore and develop community based crisis stabilization options for adults, children and adolescents;

* continue to pursue partnerships with community-based primary health care providers (e.g. physicians groups, home health agencies);

* obtain national accreditation (JCAHO);

* complete the construction of the Child, Adolescent and Family and Acute Care/ Administrative Services buildings;

* continue to pursue the implementation of a school based day treatment program with county school districts;

* develop new contracts and expand existing ones with county school districts for school based services;

* continue to make contacts with nursing homes and extended care facilities to provide mental health services to residents;

* pursue the development and implementation of a Partial Hospitalization Program for older adults;

* pursue relationships with primary care physicians to provide health care to center clients;

* expand the existing Family Preservation Program through collaboration with other agencies such as DSS and other center programs;

* expand the existing Family Crisis Intervention Program through collaboration with DJJ, the court system and schools;

* expand provision of after-school services for children through positive role models and activity therapy;

* plan and implement a community respite service open to center and non-center psychiatrically disabled teenagers and adults;

* continue to develop the Swansea/Gaston clinic into a multi-service satellite clinic;

* continue to upgrade and expand computer capability throughout the center;

* continue to develop community resources through publications, volunteer services, and public relations activities; and

* develop a partnership with a federally funded primary health care clinic(s) for center clients who do not have a primary care physician.

Orangeburg Area Mental Health Center
(Orangeburg, Bamberg and Calhoun counties)

The center revisited its mission and vision while planning strategies for the next three years. We committed our services and resources to improving the quality of life and providing the highest quality of care to clients and their families in the catchment area we serve.

Last year's goals focused on managed care, reducing of caseloads in the clinics,

initiating CARF accreditation standards, increasing computerization of clinical programs, increasing school-based services and implementing a special program for DSS-referred consumers.

A component of Integrated Delivery Systems and Services was added to the organization to specifically handle managed care issues, quality management, utilization management, consumer affairs and all indirect service delivery areas.

Since clinic staff are few in numbers and service delivery requires a vast array of service areas, a concerted effort was made to reduce the inactive caseload and cases where clients sporadically kept their appointments, usually in crises situations. An increase in targeted case management, intensive case management, consumer education courses and family education programs assisted in the accomplishment of this goal.

Considerable efforts were involved in ensuring that standards to which the center adheres were in alignment with CARF standards.

Additional computers were purchased to upgrade the capability of the functioning capacity; however, we did not achieve the 30 percent increase in electronically equipping clinical staff.

School-based services were added to three schools in the catchment area.

A program designed to assess and treat depression in DSS-referred clients was implemented in the Orangeburg area. Approximately 15 clients are being treated through a collaborative partnership with DSS and the center.

A Strategic Planning Session with staff, board members and a consumer was held to plan for the next three years.

Goals incorporated for FY 97-98 include:

* increase the number of staff who are licensed for LISW or LPC;

* develop marketing strategies to increase referral base by 30 percent and funding source by 10 percent;

* develop and implement an array of wellness activities to increase staff morale;

* increase the utilization of volunteer services by 25 percent;

* expand school-based counseling within the catchment area; and

* develop new treatment protocols for children between the ages of 3 to 5.

In FY 96-97 there were 2,770 admissions and 61,047 contacts, which represented approximately a 10 percent increase in admissions and contacts since FY 95-96.

The center looks forward to moving into two newly constructed facilities in FY 97-98. A 25,500 sq. ft. center is being developed in Orangeburg County and a 3,700 sq. ft. center in Calhoun County.

Pee Dee Mental Health Center
(South Greenville County)

Continuous quality improvement of programs and services is strengthening the center as it adjusts to a changing health care environment. In response to the center's needs, members of our Executive Management team have drafted a new vision statement which embodies the direction our center is taking. Our goals for the past year evolved from ideas generated by our Executive Management Team at our annual Leadership Conference.

The goals are as follows:

* strive to be recognized as the premier provider of behavioral health care in the Pee Dee by consumers, community leaders, agencies, other health care providers and the community at large; a Marketing and Community Service/Education campaign will be developed and implemented;

Status — Our vision statement reflects the above philosophy and has been publicized in all center literature; the Marketing and Community Service/Education campaign is underway and will be a continuous process. We have updated all Center publications and brochures, and have participated in many community events, including: Health Fairs, Mental Health Awareness Walks, and Community Training Events. This fall, we will co-sponsor three major events, an Arts and Wellness conference in Marion County, the First Ladies Women's Health Day and a training event for local law enforcement.

* to provide accessible, comprehensive and effective services for all behavioral health care needs. This will be accomplished through consumer surveys and needs assessments, CARF certification, development of more clinical treatment groups and implementation of the Level of Care model in all clinics;

Status — Consumer satisfaction surveys continue to be administered to consumers' currently receiving our services. In addition, we ask consumers to complete a survey at admission, measuring their satisfaction with the referral and intake process. We also send follow-up surveys at one month post-discharge to all consumers. We will be surveyed by CARF in September 1997. A needs assessment will be completed in September 1997 by our case management consumers to help develop alternate programming options. The Level of Care Model is implemented in all clinical locations and updated every six months. Level of Care is measured as one of the center's quarterly effectiveness measures.

* create a comprehensive MIS system in order to adapt to the changes in the health care environment. We will pilot a computerized scheduling system, design and implement Consumer Satisfaction Survey software, and develop outcome

measurement tools to aid in decision-making about programming;

Status —The computerized scheduling system is not in place. We will work to achieve this goal when the system is ready. We will explore a computerized Consumer Satisfaction tool in September 1997. We have implemented a quarterly outcome measurement tool that measures effectiveness (GAF score, level of care, goal outcomes, consumer report of severity, Self-Report of Happiness), and efficiency (staff productivity, financial stability, staff retention, service utilization rates, crisis intervention response time, referral to intake time interval).

The Pee Dee Mental Health Center board of directors and executive management team have developed goals for FY 97-98. These goals were also developed with input from the community and consumers by way of our quarterly Community and Consumer Forums. Our goals are more outcome driven than in previous years so that we can quantifiably measure our progress towards them.

Goals for FY 97-98 are to:

* increase the number of housing units available to consumers;

* increase the number of consumers employed through the center's Consumer Employment from 38 to 40;

* reduce the number of psychiatric admissions to DMH inpatient facilities to below 40 per month;

* maximize community and consumer satisfaction with center services;

* reduce the number of days for non-emergency intake services to within an average of seven working days of a consumer's initial referral;

* increase the number of local crisis stabilization beds available through contract from 0 to 2;

* maintain a balanced budget throughout the fiscal year;

* implement a new focused orientation process for center personnel; and

* recruit a child psychiatrist.

Piedmont Center for Mental Health Services
(South Greenville County)

The Piedmont Center for Mental Health Services serves southern and eastern Greenville County, a rapidly growing area in South Carolina with a wide diversity of industries and businesses. The area is experiencing a tremendous influx of new businesses and high technology industries with much of the growth occurring in the I-85 and I-385 areas. This is accompanied by many new housing starts, new apartment complexes and new families moving into the area.

To serve the growing population, the center has full-time offices in Simpsonville and Greer and a part-time office in Piedmont.

Simpsonville, located just off I-385, is the fastest growing town in South Carolina. The catchment area population has grown to approximately 165,000 and is projected to continue rapid growth into the next century.

Serving the seriously mentally ill continues to be a top priority of the center. There are numerous community based programs to provide services to this population. The center, through contractual arrangements, places clients in eight 10-bed community care homes, Ridgeview Community Care Homes and Gregory's Community Care Homes II. The center provides a Rehabilitative Psychosocial Therapy Program and other supportive services for these 80 clients.

The J. Charlie McKinney House, a 10-bed community residential program for the deaf mentally ill, was completed and opened with 10 residents in July 1994. A full range of rehabilitative services are provided for these clients with trained staff 24 hours per day. In addition, the Piedmont Center employs professional staff to provide outpatient and case management services to the deaf mentally ill in the region.

The center contracts with Gateway House to provide a program of psychosocial clubhouse services for 30 clients. The clients live at Gateway Apartments, Portals Apartments, Towers East Apartments or Piedmont Residential Center.

The Hillcrest Heights Apartments provide residences for 12 center patients. These 12 apartments were constructed with a HUD grant to the Greenville Mental Health Association.

Twelve apartments located at Victor Village provide housing for clients in the Greer area. This is another partnership project with the Greenville Mental Health Association.

Gateway House provides supportive employment services for selected clients. The center also uses the services of Goodwill Industries and Vocational Rehabilitation.

The center operates Sunshine House in Simpsonville, which is a restorative independent living skills program (RILS) and Rainbow House in Greer, which has a similar program. Crossroads, a rehabilitative psychosocial clubhouse, serves 15 clients. It began with an RPT program and became a RILS program in 1997.

The center contracts with Marshall I. Pickens Hospital, Chestnut Hills Psychiatric Hospital, and Charter Hospital of Greenville to provide local inpatient stabilization for mentally ill clients needing acute care. Other local hospitals are utilized when clients have resources to cover the cost of inpatient care.

The center relates closely with Harris Psychiatric Hospital that serves Region B of the state.

For children, the center contracts with Marshall I. Pickens Hospital Child and Adolescent Program, Anderson Youth Treatment Center and Charter Hospital for local emergency stabilization.

The center provides a family preservation service for high-risk children. All children in this project are in threat of being removed from the home and placed in a Department of Juvenile Justice (DJJ) or DMH institution. This program functions in close collaboration with the DJJ and the Family Court.

The center provides community residential treatment services for children ages 11 through 16 in the Clear Spring Home for girls and the Bethany Home for boys.

The Piedmont Center has collaborated for several years with Bryson Middle School where a full-time mental health counselor has been placed. The center has also employed and placed mental health counselors in Fountain Inn Elementary School and Woodmont High School. These counselors work with children and parents and provide consultative services to teachers and staff. Research is included in these projects.

Graduate students from the University of South Carolina serve internships in all school-based programs. Other graduate students serve internships in the Simpsonville and Greer offices and clubhouse programs.

Since July 1994, the center has collaborated with other agencies to carry out the Children's Proviso. The center has two full-time mental health counselors who work with high risk and troubled children referred by the Department of Social Services.

The Piedmont Center made much progress toward the goals established for FY 96-97. The goals and responses were:

* fill the vacancy for consumer affairs coordinator by Dec. 31, 1996;

Status — A part-time consumer affairs coordinator was hired in October 1996.

* continue to adapt and position center for continuing changes in the health care delivery environment;

Status — DMH and center are organizing and producing much better data, which is used in decision-making and planning. More reliable systems of program cost accounting and outcome measurements are being developed.

* continue the managed care efforts with the other centers of Region B and Harris Hospital;

Status — The directors and other key staff in Region B continue to meet regularly to plan and prepare for managed care, accreditation and other operational issues.

* provide needed training in Brief Therapy and other essential topic areas for outpatient clinicians;

Status — The center has sponsored specialized training for three clinicians in Brief Therapy. These clinicians are training other staff in these special techniques.

* begin construction on the planned new facility for the center in Simpsonville;

Status — The project was bid in the spring of 1997. Bids exceeded available

funds. The project will be rebid in the fall of 1997.

* review, evaluate and make needed changes in treatment and services for chronic mentally ill patients;

Status — The program at Crossroads was changed from an RPT program to RILS. A TLC III project to place additional hospitalized chronic deaf patients in the community was implemented in May 1997.

* apply for CARF accreditation by May 1, 1997;

Status — The center met this goal for application for accreditation. The survey will be done in September 1997. Staff continue to prepare for program accreditation.

The Center had very impressive statistics for FY 96-97, which include:

Total Number of Patient Contacts	-	91,459
Medicaid Receipts	-	$2,789,644.00
Admissions	-	1,764

Goals for FY 97-98 are to:

* accomplish accreditation in the September 1997 CARF accreditation survey;

* continue to refine the Chart of Accounts and cost accounting system for determining actual costs of center programs;

* re-organize center management and supervisory lines to be in accord with program delineation in the Chart of Accounts;

* develop a plan for center participation and service delivery in collaboration with the Charter School Project (kindergarten for four-year olds at risk) in Fountain Inn and implement the plan by Dec. 1, 1997;

* increase the use of group therapy by increasing by 30 percent the volume of patient contacts in group therapy in FY 97-98 in comparison to FY 96-97; and

* rebid the Simpsonville Building project by Oct. 31, 1997, and begin construction by Jan.15, 1998.

Santee-Wateree Community Mental Health Center
(Sumter, Clarendon, Kershaw and Lee counties)

FY 96-97 could best be described as a year of teaching an old system new tricks. The ever-changing field of mental health care delivery arrived with managed care mandates for the center this past fiscal year.

Due to the large population of military dependents in the Sumter area, Santee-Wateree became one of the first community mental health centers in the state to sort through the maze of pre-authorization of services, utilization of service issues, and co-pays for services. The changes happened rapidly, and the center responded in record time to this new environment.

To respond to the demands for pre-authorized services, particularly with our

military community, the center planned and opened the Sumter Counseling Services in less than three months. The center is especially proud that this high quality service site can offer any resident of this geographic area an array of traditional outpatient therapies.

All staff at this location are fully licensed by the state in their highest field of expertise.

The center performed well toward meeting goals established the previous year. Following are the outcomes achieved for each previously set goal:

* seek national accreditation;

Status — The center continues to work toward this goal and expects to be accredited by CARF by July 1, 1998. Early evaluations of our service delivery sites revealed issues that needed to be addressed to bring our sites in line with safety standards. The center is currently addressing these problems.

* increase psychiatric coverage;

Status — The center was able to recruit and employ a full-time child psychiatrist. Our effort to recruit a psychiatrist for adult services was also successful; however, we also lost a psychiatrist, so we had no net gain in psychiatric time for adults. In fact, with the increased number of consumers seeking services, our ratio of doctors to clients actually worsened. Without additional funding for another psychiatrist, this situation is not expected to improve this year due to the center's budget deficit.

* fully implement the Federal Supportive Employment Grant;

Status — The center has successfully implemented this goal. We currently are at the midpoint in enrolling consumers in this five-year follow up study. Approximately 60 percent of the consumers enrolled in the project have been employed at one time or another since entering the program. The center's supportive employment activities compare favorably with the other national grant sites.

* begin a center-wide utilization and review process;

Status — The center found it necessary to modify this goal midway through the year. With the penetration of managed care into the Sumter area, this goal was modified so that we began a stringent utilization and review process for the newly created Sumter Counseling Services— a site serving people with traditional outpatient therapy needs.

* encourage qualified staff to obtain licensure and credentialing in their field;

Status — Utilizing internal staff resources, the center provided on-site supervision to 16 staff seeking LPC licensure and two staff seeking LISW certification. To date, three staff have completed the necessary hours of clinical supervision and have sat for the exam. The center also had two staff that received licensure as LMSWs and one staff who was certified as an LPC Supervisor.

Center goals for FY 97-98 are to:

* continue to seek CARF accreditation;

* expand housing opportunities to the more rural counties, particularly Kershaw;

* evaluate and realign existing center programs based on consumer needs, clinical needs and consumer preference; and

* develop a protocol and a memorandum of agreement with Kershaw County for on-site services to Kershaw County jail.

Spartanburg Area Mental Health Center
(Spartanburg, Union and Cherokee counties)

Progress toward identified goals for FY 96-97 includes the following:

* remain fiscally sound; incorporate client-centered use of new/per capita funding;

Status — Since 1987, this center has ended the year within budget. That is true again this year — a local effort that was complemented by DMH's bringing of per capita funding more in balance with other centers.

Of the 12 clinical positions and six administrative support positions requested for using part of the $738,114 in new/per capita funding for FY 96-97, nine of the clinical and one of the administrative support positions were filled.

To avoid a deficit, two of the clinical positions had to be frozen. One administrative support position was not needed nor was lease funding, due to the change in the need for one department to move. (That money was "saved" by the generous offering by Spartanburg Regional Medical Center to offer interim housing for the Spartanburg office.) Some funding for administrative positions was used for temporaries while willing/appropriate employees are sought. Contracts with Upstate Carolina Medical Center, Gaffney, and Wallace Thomson Hospital, Union, were not achieved, but the negotiations have resulted in improved relationships.

* Retain current staffing level; fill other vacancies as funding is available;

Status — There was an overall gain of seven clinical staff and an overall loss of three administrative support staff. (Seventeen clinical staff were hired, while 10 resigned/retired.)

Six of the 17 clinical staff hired were in children's services, and seven were in Community Rehabilitation/Case Management (formerly CSP), clearly reflecting our priority populations. Two other staff were hired into the Psychosocial Rehabilitation Program (formerly RILS), and the remaining two were one psychiatrist and one nurse. Six of the new staff were assigned to the Union Mental Health Center.

* Purchase a site for a new main center and hold ground breaking;

Status — Notice was received in June 1997 that the "property transaction had been closed," exciting news for Spartanburg Area Mental Health Center after years of

effort. This success came with Spartanburg Regional Medical Center's willingness to swap some desirable land for the current center building. This win-win transaction further opened the door for Spartanburg Regional Medical Center to offer the center temporary housing in one of its clinic buildings being vacated in the fall of 1997.

The clinic building will adequately house the Spartanburg Center while a new building is under construction nearby.

A ground breaking for the new building will be held during FY 97-98, and a celebration of farewell will be experienced when Spartanburg Regional Medical Center bulldozers demolish the building that Spartanburg Area Mental Health Center has called home for decades.

* Continue efforts toward Managed Care by achieving Commission on Accreditation of Rehabilitation Facilities accreditation;

Status — While managed care activities per se have somewhat decreased, we continue to position ourselves to remain a state-of-the-art provider in the mental health care market knowing that clients and their families will continue to need our services regardless of the details in federal/state and private insurance plans.

Therefore, our major effort during this year has been to prepare for a site survey (Sept. 24-26, 1997) by CARF toward receiving a full three-year accreditation for outpatient, crisis intervention, case management and psychosocial rehabilitation programs. Accreditation will be one primary measure that insurers will expect of providers, and consumers deserve the affirmation of "best practice" that accreditation provides.

This effort has cost thousands of dollars and thousands of person-hours of effort, but has already improved care by causing our facilities to be safer, our staff to work more in teams and to formalize some planning efforts, our agency to receive and use increased input from the people we serve as well as having increased our involvement with our board of trustees and focused our interactions with our state office.

Other accomplishments include:

* Total client contacts for FY 97 were 92,310 (compared to FY 92: 62,340; FY 93: 66,070; FY 94: 77,600; FY 95: 89,566; FY 96: 92,272) of which 11,081 (FY 92: 7,898; FY 93: 10,280; FY 94: 12,163; FY 95: 11,896; FY 96: 11,905) were through New Day Clubhouse. The unduplicated number of clients served was approximately 6,039 (FY 92: 5,080; FY 93: 5,150; FY 94: 5,721; FY 95: 5,934; FY 96: 6,249) of which 131 (FY 92: 133; FY 93: 154; FY 94: 150; FY 95: 136; FY 96: 155) were served at New Day.

* Volunteers contributed the equivalent of $39,055 through 4,567 hours of service. These 23 people were formally recognized at an event to which staff and the board of trustees were invited.

* Another successful Quality Assurance Survey was held in mid-September 1996.

* Stabilization Team members were reorganized into Medication Management Services. This team of nurses has provided services in a medication clinic for adults and another for children. They provided medication monitoring services for clients from various center departments and to selected Level I (psychiatrically stable, functioning in the community, at home and/or work, requiring medical services only) clients.

* The center's largest department, both in terms of clients and staff, Community Support Program (now Community Rehabilitation/Case Management), gained a full-time director. They continue to improve services under her leadership. Part of that staff continue their involvement in the Clinical Rehabilitation Team (CRT) efforts.

* "Video-phone" services used with deaf clients in Spartanburg having psychiatric medical assessment with a psychiatrist in Charleston who can communicate with the deaf have proven to work so well that other departments are seeking its use. A company in Greenville plans to donate a unit to the center due to their employee's positive impression of the center's services.

* The Homeless Coalition for Spartanburg, Cherokee and Union counties has provided leadership for and become a constituent of an upstate homeless coalition to make planning and grant requests to Housing and Urban Development more successful.

* The development of school-based services continues in all three counties with staff identified and varying degrees of collaboration with the schools.

* After years of local planning and with major funding assistance from DMH, the Spartanburg Detoxification Center opened Oct. 25, 1996, and held an Open House March 10, 1997.

* The center spent $31,516.51 for continuing education of 87 different clinical and administrative support staff.

* Several center staff participated in various statewide efforts including the revision of DMH Standards and CARF "mock" surveys.

* The Union Mental Health Center and the Mental Health Association co-hosted at the center an "After-Hours" event for the local Chamber of Commerce.

* The Spartanburg Center received a visit from the new state director of mental health April 23, 1997.

* Through Consultation, Education and Prevention services, 39 staff members provided 598 offerings for a total of 1,847 hours, with $14,389.92 collected for these indirect services.

Continuing efforts of note include:

* monitoring of Continuity of Care requirements;

* outposting of a staff member at the Village Partnership and at the South

Carolina School for the Deaf and Blind;

* an annual staff development retreat;

* staff development offerings based on an annual needs assessment and sometimes providing CEUs;

* providing clinical experiences for a variety of students, producing an internal newsletter;

* "sharing" a position with Vocational Rehabilitation;

* providing consultation to Woodruff Health Care;

* supporting the Mental Health Partnership;

* participating with various local authorities in emergency preparedness;

* beginning efforts for a catchment area-wide Crisis Response Team;

* recognizing employees including honoring an Outstanding Employee;

* building relationships with community residential care homes and services;

* improving transportation for clients;

* building a system of client advocacy;

* contracting with selected providers for specific needed services and monitoring those contracts;

* providing required staff training (CPR, first aid, fire safety, etc.); and

* infectious disease control.

Goals for FY 97-98 are to:

* remain fiscally sound;

* pursue increased funding in Cherokee and Union counties;

* pursue millage in Spartanburg County with assistance of board of trustees;

* retain current staffing level and fill other vacancies as funding is available. (There is a special concern for medical coverage, particularly for C&A services.);

* hold a ground breaking for a new Spartanburg County facility;

* assist architects and contractors during construction;

* upfit and move the Spartanburg office into temporary facilities offered by Spartanburg Regional Medical Center;

* continue emphasis on program evaluation and outcome studies as well as emphasis on input from persons served;

* achieve CARF accreditation;

* make permanent capital improvement request for both satellites; and

* host a 50th anniversary celebration.

Tri-County Community Mental Health Center
(Dillon, Chesterfield and Marlboro counties)

This center serves a rural, three-county area that has struggled with serious problems this year. There have been a number of plant closings that have left this area with an extremely high unemployment rate.

Our center has worked closely with other agencies to address community issues. Those efforts resulted in several small collaborative grants.

Because this is a high poverty area, the center has relied heavily on Medicaid earnings. As that funding has become tighter, the center has struggled with its budget. A number of staff positions have been left vacant in administration and administrative support services including our PR/Volunteer position. There is a continuing shortage of medical coverage. Despite this, Tri-County has the highest per capita case load of any center in the state. There was a 9 percent increase in the center's caseload this year despite a reduction in staff.

This year, the center focused on creating some additional service options for consumers with serious mental illnesses.

The Next Step Program provides an option for people who have accomplished what they can in the Living Skills Clubhouse. This program gives them the opportunity to choose how much time a week they need and what areas of programming they want.

One focus of the Next Step program is pre-employment. While the center has only one staff member working on vocational issues, that program has had some good successes with people going back to work and to Vocational Rehabilitation Services.

SHARE has been working with the center to bring a drop-in center to our area. SHARE hired a consumer staff person, and the center is providing the space.

The center recently received funding for a Homeshare project and is in the process of trying to get that program started. That will give the center a new housing option for people coming out of the hospital.

Staff has worked hard this year to create stronger links with clients when they are in the hospital. As a result of those efforts, Tri-County met its goal to bring down its bed day use rate and will continue to work on it. The commitment rate for this center has been high over the past years, and there was less success with that. Still, Tri-County was one of only five centers in the state to see any reduction in their rate.

Despite budget issues, Tri-County has been able to continue some of its dual-diagnosis programs. The therapeutic nursery program was consolidated into one site and continued when grant funds ended.

Tri-County began a tele-video service this year in conjunction with Hall Institute, which provides the center with needed child psychiatric consultation. A pilot project is in the works for a long-distance learning project for our staff through Hall Institute

and S.C. Educational Television.

Staff in Dillon moved into their new building in May, and the old building is now being used for a much needed clubhouse expansion. Plans are for Chesterfield to start its new building this fall.

This year, Tri-County will continue to work toward accreditation and on strengthening outcome measures. However, good data management will mean improved computer systems with improved access for clinicians.

Goals for FY 97-98 are to:

* reduce center annual bed day use to 22,900 this year and keep commitment rate at or below this year's rate;
* obtain national accreditation;
* complete the Chesterfield building; and
* have outcome measures and baselines for every center service.

Waccamaw Center for Mental Health
(Georgetown, Horry and Williamsburg counties)

Waccamaw Center provides services to the people of Horry, Georgetown and Willamsburg counties — a region of diverse economics, populations and mental health needs.

For example, the coastlines of Horry and Georgetown counties constitute the Grand Strand of South Carolina, which has an extensive tourism industry that may bring in half a million visitors in one weekend. The clinics in those counties provide emergency services to this group as well as the year-round population.

The western sections of these counties and all of Williamsburg County are primarily rural and agricultural. Horry continues to be one of the fastest growing counties in the United States, with needs for services keeping pace with that growth.

Center wide, total admissions for the fiscal year were 3,967, and as of June 1997, there are 3,771 active cases.

Goals for the past year included beginning a new facility in Georgetown County — funds have been designated for that project. Consumers, management and staff have been working to design a building that meets the needs of that county. Land has been donated from that county government. Construction will begin within the next four months.

The center has been actively working toward accreditation from the Commission on Accreditation of Rehabilitation Facilities. The review is scheduled to take place in November or December 1997.

Complete descriptions of the programs to be accredited have been written with input from staff, consumers and the community. A Plan of Operation has been

completed describing how those services will be delivered. This process has required reviewing all aspects of center operations and service delivery. Consumer involvement and Outcome Evaluations are key elements in determining center efficiency, treatment effectiveness and consumer satisfaction.

Priority services are those for people with chronic mental illness and for emotionally disturbed children. Other services are provided as resources allow.

The center has the lowest ratio of hospitalization in our region. There are no waiting lists, and each clinic provides evening hours.

The type of outpatient service, based on consumer needs, is identified by levels of care; and in most programs, the service is provided by treatment teams. By utilizing a team approach, we offer the consumer access to a number of clinicians with a variety of skills.

Children's services have continued to expand, primarily in the area of school-based services. This innovative program places counselors in schools full-time, providing services to children and their families in a familiar environment. There are now more than 30 counselors in this program compared with 20 last year.

A continuum of services for children and their families begins with Family Intervention Services (birth to age three), Babynet (age three to five), Head Start (age four and five) and continues throughout school. Active child and adolescent cases have increased by 18 percent during the last year.

A number of grants have been continued. As an example, the PATH grant enables the center to provide emergency funds to the homeless mentally ill. This grant has been continued and expanded for the coming year.

Unfortunately, 23 units of housing the center helped two private non-profit organizations to acquire for the temporary housing of the homeless mentally ill via the McKinney Act will not be available.

Williamsburg County currently has a unit housing four consumers, and housing will be developed in each county within the next year.

The center received funding for a Toward Local Care program, which will assist in providing intensive services to adults with a history of repeated hospitalizations.

This center is committed to responsible financial management and has recently undergone a complete audit in this area. In FY 96-97, the center finished with a small carry-over of funds while continuing to expand programs. Provided there are no changes in current funding structures, the center expects to finish next year in the same fashion. Funding from Horry County has been increased, and other counties continue to provide much needed financial support.

Partnering with other agencies and health care facilities in our area continues, as does the center's long-term commitment to providing placements for interns from a

number of colleges and universities. Clinical supervision and continuing education of all staff are priorities.

Goals for FY 97-98 are to:

* locate resources for a new facility for the Kingstree Clinic;
* develop housing for consumers;
* complete the accreditation process;
* expand children services; and
* work with consumers and other agencies to increase accessibility of services.

At the time of this report, the center is developing a program with the Department of Juvenile Justice to provide intensive intervention to at-risk adolescents. A children's psychiatrist is the priority for new staff.

Inpatient Services

Bryan Hospital
(G. Werber Bryan Psychiatric Hospital)

In the FY 96-97, Bryan Hospital had a record number of 4,536 admissions. This compares with 3,607 admissions in FY 95-96.

In October 1996, Bryan took a unit from Crafts-Farrow and located it on the newly renovated Lodge A. Since then, Bryan has been admitting patients 60 years and older for acute psychiatric care.

Bryan has been able to meet the challenge of the increased admissions by decreasing the average length of stay for patients.

In FY 95-96, the average length of stay was 20.64 days. In FY 96-97, this was reduced to 16.84 days.

Space in the admissions area of Bryan has been rearranged, but this area is still crowded for the number of admissions we process.

The administration at Bryan Hospital has changed. Since February, we have a new director, a new administrator, a new nurse executive, and a new director of Professional Services.

The result is dynamic new leadership that has brought about the following changes at Bryan:

* a new mission and vision statement (*The full resources of Bryan Psychiatric Hospital are dedicated to providing quality psychiatric care for citizens of South Carolina age 16 years and older.*);
* a new organizational chart;
* improved communication between administration and staff through:

(a) The senior management team met with all three shifts to introduce the new administration and to answer questions from staff;

(b) A *Flashline Bulletin* is sent out as a flyer to all staff to communicate any information that administration wants to reach staff quickly; and

(c) A *Director's Hotline* has been opened so staff can call at any time and get a call back from the director within 24 hours;

* lodge-based programming has been started, with more groups and activities being held on-lodge rather than off-lodge, providing more programming for patients who are not ready to be allowed off the lodges; and

* much needed paint and patch work has been accomplished in the past few months under the direction of the new administrator.

Goals for FY 97-98 are to:

* continually enhance the quality of care;
* identify opportunities for organizational improvement;
* build a culture of trust and communication; and
* be certified by local and national organizations.

Byrnes Center
(James F. Byrnes Center for Geriatric Medicine, Education and Research)

Byrnes Center has maintained excellent service standards during the past fiscal year, while planning for and undertaking significant changes.

Traditionally, Byrnes was a 166-bed general hospital providing medical-surgical support for DMH's inpatient facilities.

DMH's emphasis in recent years has been on community-based care. This has resulted in a gradually declining DMH inpatient census overall. However, as the inpatient population downsizes, the core population of institutionalized, chronically mentally ill patients is aging, and DMH is maintaining about 700 nearly fully occupied long-term care beds at the Tucker/Dowdy Garner Nursing Care Center.

This increasingly aged, medically complex inpatient population led the Byrnes Center leadership to organize the facility in recent years as the James F. Byrnes Center for Geriatric Medicine, Education and Research, thereby attracting a professional staff skilled in geriatrics to provide appropriate acute services to this population, as well as to serve as a Department-wide resource in addressing geriatric/geropsychiatric needs.

Byrnes saw a 21 percent increase in the number of admissions during FY 96-97 over the prior fiscal year — a trend which may be expected to continue as the number of aged members of the population grows.

A new inpatient infirmary service was developed to meet the needs of patients

stepped down from acute care, those awaiting placement, and other patients whose short-to-intermediate-care medical needs could be better provided at Byrnes than in their home facility.

The Utilization Review program was enhanced to facilitate the movement of patients between facilities and better accommodate their changing needs.

Byrnes staff provided significant consultative, training and clinical services toward improving clinical approaches to the elderly mentally ill. An example of this was Byrnes' consultation, development and user training on an outcomes assessment tool for Project COPE, the Lexington Alzheimer's Partnership.

This initiative was undertaken by the Lexington Community Mental Health Center, the Governor's Office Division on Aging and others (under a grant from the U.S. Public Health Service) to provide community-based care for Alzheimer's patients and their families, with a goal of preventing or delaying institutionalization.

Given DMH's emphasis on community-based care, Byrnes' outpatient and ancillary services have continued to expand in several areas. The Byrnes Pharmacy assumed responsibility for operating a satellite pharmacy at Hall Psychiatric Institute starting Oct. 1, 1996.

The Byrnes clinical laboratory took over various drug screening and toxicology procedures for Morris Village that were previously done on contract with an outside service.

The physical therapist instituted a program of weekly patient consultations on Lodge A at Bryan Psychiatric Hospital as well as providing inservices to staff.

The Radiology Department continued to provide extensive outpatient services to the S.C. Department of Corrections and is exploring the possibility of expanding services to the Department of Juvenile Justice.

We are also proposing to expand urgent care and diagnostic services to other state agencies that have 24-hour life safety responsibilities.

The Department of Nursing developed a case management program to reduce the number of repeat admissions, improve interfacility continuity of care, improve the overall health status of patients served by Byrnes and to coordinate care for improved efficiency and efficacy of services.

Over the past fiscal year, approximately 30 percent of the budget and 32 percent of the staffing complement were committed to outpatient/ancillary activities. Based on current utilization trends, the budget forecast for the coming year shows a continuing shift of budget commitment to outpatient/ancillary services.

The quality of services provided at Byrnes was extensively evaluated in FY 96-97. In July 1997, the institution received another three-year accreditation from the Joint Commission on Accreditation of Health Care Organizations, sustaining a status it has

held continuously for 30 years.

In September 1996, the Clinical Laboratory underwent an on-site inspection and received complete CLIA/CAP accreditation for another two years.

Byrnes participated in a cooperative project with Carolina Medical Review, the professional review organization for North and South Carolina, and received commendation on its pressure ulcer prevention program as well as being asked to present at a statewide quality improvement program sponsored by the PRO and being featured in the Quality Partners publication.

The Byrnes' staff continue to plan for success through their strategic planning process, which is in its third year of implementation. Under the some general goals and subgoals, objectives and action plans for FY 97-98 are being drafted and will be in place by the end of August 1997.

Special planning emphasis this year will be placed on addressing issues identified during the JCAHO survey, implementation of outcome measurement processes and meeting JCAHO monitoring requirements, integration of research toward improvement of the quality, accessibility and cost effectiveness of care, and active support of the overall DMH strategic planning process.

Division of Psychiatric Rehabilitation Services (South Carolina State Hospital and Crafts-Farrow Intermediate Care Facility/ Mental Retardation)

The Division of Psychiatric Rehabilitation Services (DPRS) completed the consolidation process that started in FY 95-96. Both populations (long term psychiatric patients and patients with functional impairment due to aging and/or disease) are present on the Bull Street campus.

The acute geriatric psychiatric patients, who were housed on Ward 137 at Crafts-Farrow State Hospital, have completed an administrative reassignment to G. Werber Bryan Psychiatric Hospital. Thus, Intermediate Care Facility/ Mental Retardation Program is the only DPRS program that continues to reside at the old Crafts-Farrow campus.

During the fiscal year, one additional ward (Ward 120, Williams Building) was reopened, which brings the bed capacity to 376 beds on 12 wards.

The division continued the process that began last year, grouping the patient population by functional and treatment needs instead of definite age criteria.

The surplus list of employees, which resulted from the merger last year, has been reduced from 11 to four. We are continuing efforts to relocate these employees to other hospitals or community mental health centers.

The division has continued to focus on the integration of the two previously

distinct hospital cultures with the goal of taking the best attributes from both.

After the completion of the consolidation, staff education was offered. The first educational area was to help both former cultures understand the needs and dynamics of two differing populations — long term psychiatric population and functionally impaired due to aging and disease process.

The second educational emphasis was geared to improve treatment team documentation and functioning. The treatment plans were strengthened to involve multi-problems and/or functional needs of the patient. The treatment team documentation is now addressed by an ongoing professional competence program for all regular treatment team members.

In the area of treatment functioning, further clarification was given to roles of case management and documentation responsibilities. A renewed emphasis was given to treatment team functioning that would demonstrate patient participation and monitoring treatment outcomes.

Clinical staff training continues to target the special needs of the patients with an emphasis on problems caused by functional decline and aging. A committee is working on the design of a treatment modality and services for the patients, who are dually diagnosed with mental illness and other alcohol/drug abuse.

The division committees and leadership continue to improve organizational structure and functions to comply with accreditation and licensing requirements. The division ultimately seeks performance outcome measures that provide evidence that the programs are meeting the patients' needs and expectations.

The Intermediate Care Facility for the Mentally Retarded Program on the Crafts-Farrow campus provides rehabilitation and health care for developmentally impaired clients, who have a diagnosis of mental retardation with a co-existing mental illness.

This facility is certified and licensed by the Department of Health and Environmental Control for 70 beds and for reimbursement by the Health Care Finance Administration (HCFA). The ICF/MR Program is in process of implementing a computerized system to develop individual training/ tracking programs as mandated by HCFA.

Individually designed programs are developed based on the developmental model through a multi-disciplinary approach to resemble, as closely as possible, conditions of every day life in the mainstream of our society. Focus on normalization resulted in the modification of the institutional look and allowed our clients to personalize their environment. ICF/MR continues to finalize plans for CARF accreditation.

Hall Institute
(William S. Hall Psychiatric Institute)

Hall Institute identified six general goals for FY 96-97. Those goals and the progress made on each are listed below:

* to recruit high quality trainees in the General Psychiatry, Child and Adolescent Psychiatry, and the Forensic Residency Programs;

Status — This was definitely accomplished. The General Psychiatry Program recruited six first-year students and one second-year student into the program. The Forensic Residency Program filled both positions, including a graduate of the Child and Adolescent Program. The Child and Adolescent Program has acquired three trainees, including one trainee from the General Residency Program.

* to respond adequately to the Legislative Audit Council's recommendations;

Status — New policies have been drafted concerning the Clinical Faculty Practice Plan.

* to improve communication at all levels within the Institute;

Status — Different forms of communication are being utilized to improve communication, such as monthly forum meetings available to all staff on every shift and a newsletter that is attached to pay stubs for employees.

* to reduce contract costs by fully implementing Medicus, central staffing and personnel manager;

Status — The Medicus System is now on all units, but we do not feel that it is fully utilized. Recent additional missions and delays in hiring procedures have had a great impact on our contract costs. Scheduling has been centralized for the entire facility.

* to complete competency requirements for all staff, effectively tie-in components with the hospital's total quality improvement programs to provide staff with goals and objectives that fit with the Institute's mission and vision;

Status — Competencies for the clinical staff have been developed and updated for the Joint Commission survey. The new, updated competencies will be completed by September 30. Employees have participated in quality improvement programs and are given updated on various programs monthly.

* to obtain a satellite pharmacy program at the Institute, develop adequate patient medication profiles, move to daily cart exchanges for acute care units, and to improve the automated MAR system;

Status — A satellite pharmacy is in place and working well. Cart exchanges are conducted daily, and a new medication profile system has improved information flow along with the MAR system.

Other accomplishments during FY 96-97 included:

* maintained fiscal responsibility by staying within budget constraints;

* received accreditation with no deficiencies in the Health Care Financing Administration (HCFA) survey;

* established a Young Adult Program for the Department of Juvenile Justice subclass individuals who have (and will) aged out of the system;

* completed the evaluation of the employee survey results with the help of Dr. McClure; and

* successfully recruited a new director for the Institute.

Goals for FY 97-98 are to:

* effectively manage transitions in administration;

* maintain accreditation with JCAHO;

* complete the implementation of Medicus;

* stay within budget and maintain fiscal responsibility; and

* continue to rectify problems identified by Dr. McClure in our employee survey.

Harris Hospital
(Patrick B. Harris Psychiatric Hospital)

Harris Hospital, located in Anderson, successfully accomplished its mission of providing intensive, short-term, psychiatric diagnosis and treatment to the citizens who reached out for behavioral health care from Region B, the 14 counties of upstate South Carolina.

This public inpatient facility provided emergency voluntary and involuntary psychiatric patient care for the geriatric, adult and adolescent communities needing its services. Moreover, specialized programs for substance abuse disorders and the hearing impaired (state wide) were also provided. All patients are served on the basis of clinical need, and no patient is denied on the basis of ability to pay.

Behavioral health care facilities continue to function in a turbulent economic environment. Public and private delivery systems alike find themselves confronting rising health care costs that in turn drive discussions of privatization, partnering, health care reform, etc.

Harris Hospital has not been immune to these changes, but has chosen to evaluate these changes as opportunities to enhance the future of public behavioral health care by shaping its services in anticipation of future realities.

Harris Hospital's mission, vision and value statements provide direction to its services and are essential components of its use of strategic-planning process to predict and plan wisely for the future.

During FY 96-97, the agency and hospital leadership laid the groundwork for a reassessment of agency and facility organizational culture and structure. The estab-

lishment of a geropsychiatric program this fiscal year provided a valued service and program to Region B. The implementation of the geropsychiatric program, in addition to the already existing adolescent, adult, substance abuse and hearing impaired psychiatric programs, reaffirmed Harris Hospital's value to upstate South Carolina in a highly visible manner and is an essential and, heretofore, missing component of a regionalized service delivery system.

Financially, Harris Hospital ended the fiscal year with a modest surplus, despite receiving approval to carry over moneys to FY 97-98 for the pharmacy renovation project. This surplus was achieved despite a 14 percent admissions increase during FY 96-97 and was the direct result of significant emphasis on, and enhanced precision in, the management of financial resources.

Diversity in sources of revenue and cost-containment have been significant keys to Harris Hospital's financial success. Increased Medicaid revenue, primarily from the adolescent program, was utilized by Harris Hospital to increase its mental health specialists to handle the increased workload while reducing direct care staff to work every other weekend (significant issue in staff burnout).

Harris Hospital utilized its staff vacancy factor to offset this expenditure and still remain within authorized budget. Moreover, Harris Hospital expects this action to reduce the turnover in this personnel classification and enhance recruitment.

Current discussions at the state and national level in the area of health care finance and reform create doubt as to the continuance of such funding in future years. Harris Hospital's commitment to strategic planning and emphasis on anticipating future events should enable the facility to anticipate and position the organization to respond to these future demands.

Accomplishments for FY 96-97 include:

* providing services to 2,904 patients, including 2,156 adult psychiatric admissions; 231 adolescent admissions; 403 substance abuse admissions; 100 geropsychiatric admissions, and 14 hearing impaired admissions;

* implementing a geropsychiatric program for patients aged 65 and over; geropsychiatric admission criteria was approved by DMH, and the program became operational on Aug.1,1996.

* utilizing performance improvement to enhance the quality of care provided to its patients; we continued to partner with the Region B mental health centers to ensure an integrated, community based system of patient care;

* recommending to DMH management to describe all of the facility's 206 beds as funded with no increase in revenue;

* providing through its Pharmacy Department economic prescription services (8,803 processed), on-site consultant pharmacist reports (62 visits) and patient/staff

drug education on-site services (18 programs ranging from one to six hours in length) to the Region B community mental health centers, with the exception of Spartanburg Area Mental Health Center, in support of continuity of care;

* successfully recruiting additional psychiatrists and other professional, administrative and support staff;

* expanding and continuing to upgrade our information management capabilities to access and share comprehensive patient information promptly;

* developing a costing of activities by major program and support services; this financial information will assist the hospital and agency leadership in assessing the cost and value of Harris Hospital's service efforts during future fiscal years;

* accomplishing a team mentality in preparing for the JCAHO survey scheduled for July 14-17, 1997; this teamwork allowed the entire hospital community to focus on one goal, maintaining Harris Hospital's current JCAHO Accreditation with Commendation.

* striving to ensure that funding for capital expenditures required for improving and maintaining the hospital environment was received; this included, but was not limited to, roof repairs and renovation of the Pharmacy.

Goals for FY 97-98 are to:

* actively recruit, develop and retain competent clinical, administrative and support staff as appropriate;

* ensure that capital expenditures required for improving and maintaining the hospital environment and physical plant for patients and staff are an integral and significant part of the budget formulation and expenditure process by Harris Hospital in conjunction with the DMH;

* collaborate across the hospital's divisions on a plan for continuing organizational improvement; and

* inform, support and interact with the governing body to successfully attain the goals and objectives that have been established for DMH.

The transitions and changes affecting public behavioral health care occurring during FY 96-97 have served to make Harris Hospital stronger as its leadership embraced not only change but also the "opportunities" it represents. Harris Hospital, in concert with DMH leadership, has addressed significant challenges during the past year for the hospital, the region and the Department. Significant advances in implementation of a seamless regionalized system of care have been observed. It is anticipated that such proactive and collaborative efforts will be facilitated by the planning focus being initiated on a statewide basis by the Department.

Morris Village

(Earle E. Morris, Jr., Alcohol & Drug Addiction Treatment Center

Goals for FY 96-97 included:

* enhancing the treatment outcome evaluation process;

* continuing the development of the assessment protocol to be used by the Division of Alcohol and Other Drug Abuse Services (DAODAS) and Morris Village;

* evaluating treatment design to include lower levels of care;

* continuing the strategic planning process; and

* providing training on issues of alcohol and other drug abuse treatment to community mental center staff.

Treatment Outcome Evaluation Process:

Modifications to the system to measure outcomes that can be linked to the services provided is an ongoing process. Primary objectives for the detoxification, adult rehabilitation, adolescent, and dual-diagnosis programs are designed to measure effectiveness, efficiency and customer satisfaction with services. The system is also designed to gather data indicative of improved functioning and harm reduction as well as abstinence.

Assessment Protocol:

Discussions between Morris Village and DAODAS around the issue of a common assessment protocol continue. Morris Village clinical staff have been trained in the use of the Addiction Severity Index, a nationally standardized relatively brief, semi-structured interview designed to provide important information about aspects of a patient's life which may contribute to the substance abuse syndrome. It can be described as the first step in understanding the full range of problems for which the patient is seeking help and provides the basis for the initial treatment plan.

Development of Step Down or Intensive Outpatient Unit:

Efforts to redesign treatment services to include alternatives to the inpatient level of care have been unsuccessful, primarily due to financial constraints. The Morris Village Governing Body will continue to explore options for establishing lower levels of care, in keeping with the national trend in substance abuse treatment to match patients with the appropriate level of care, minimizing the use of inpatient care for routine substance abuse treatment.

Strategic Quality Planning:

The planning/document development phase has been completed; the implementation phase is well underway. The objectives identified in the document are designed primarily to improve substance abuse treatment services.

Provision of Training to Community Mental Health Center Staff:

The facility director is working in collaboration with Hall Psychiatric Institute and

USC School of Medicine staffs to provide training on dual-diagnosis assessment through a distance education format. The first session is scheduled for October 1997.

Goals for FY 97-98 are to:

* continue modifications and revisions to the Outcome Evaluation System and link outcomes to those developed by DMH;

* implement the ASI and continue to work with DAODAS to assist that agency with implementation;

* enhance and expand treatment services to dual-diagnosis patients;

* with expert consultation, evaluate and modify the treatment model for adolescent patients;

* continue to evaluate services to pregnant women;

* enhance treatment design to ensure appropriateness of inpatient admission, and the provision of stages of treatment that address the individual needs of patients;

* continue to modify the physical plant to improve safety; and

* obtain three-year re-accreditation in 1998.

Tucker/Dowdy Gardner
(C.M. Tucker Jr./Dowdy Gardner Nursing Care Center)

C. M. Tucker Jr./Dowdy Gardner Nursing Care Center staff continued to be committed to the facility mission of providing quality care to its long-term residents. All organizational levels were active participants in the improvement of resident care outcomes during the fiscal year.

Concrete examples for the year were:

* physical restraint usage continued to decline — the average rate of usage was approximately 3 percent;

* first phases of the Stone Pavilion renovation project were completed;

* the home-like environment project that was begun last year, continued to be enhanced with the addition of carpet, wallpaper, murals and new furniture;

* both campuses had outstanding DHEC surveys;

* customer satisfaction surveys were developed and distributed for feedback on facility performance;

* newly acquired pressure sores acquired per population averaged approximately 1 percent;

* quality improvement teams focused on reducing the number of resident falls and on dignity and resident rights issues;

* the facility *Administrative Manual* was given a new format by using the JCAHO 11 important functions in long term care; the purpose was in part to prepare for the accreditation survey and to make it easier for staff to locate specific policies; and

* a new visiting room was opened and decorated in Roddey Pavilion to provide privacy for families and other visitors to meet with residents.

Goals for FY 97-98 are to:

* continue improving program services for residents manifesting psycho-behavioral problems;

* continue improving clinical and administrative processes through employee empowerment, quality improvement teams and the principles of TQM;

* operate within the budgetary allocations provided;

* implement the budget through a budget planning committee to monitor and review outcomes and cost effectiveness of programs and services;

* implement computerized acuity and staffing system;

* continue JCAHO accreditation; and

* maintain licensure and certification requirements.

Richard Michael Campbell Veterans Nursing Home

Staff continued to strive to give the quality of care to the veterans of our state.

Goals for FY 97-98 are to:

* maintain licensure, certification and VA requirements for all programs;

* operate the facility within budget authorizations;

* continue restraint reduction program which has successfully reduced restraint usage to less than one percent;

* improve the environment with scenic murals painted by local artist;

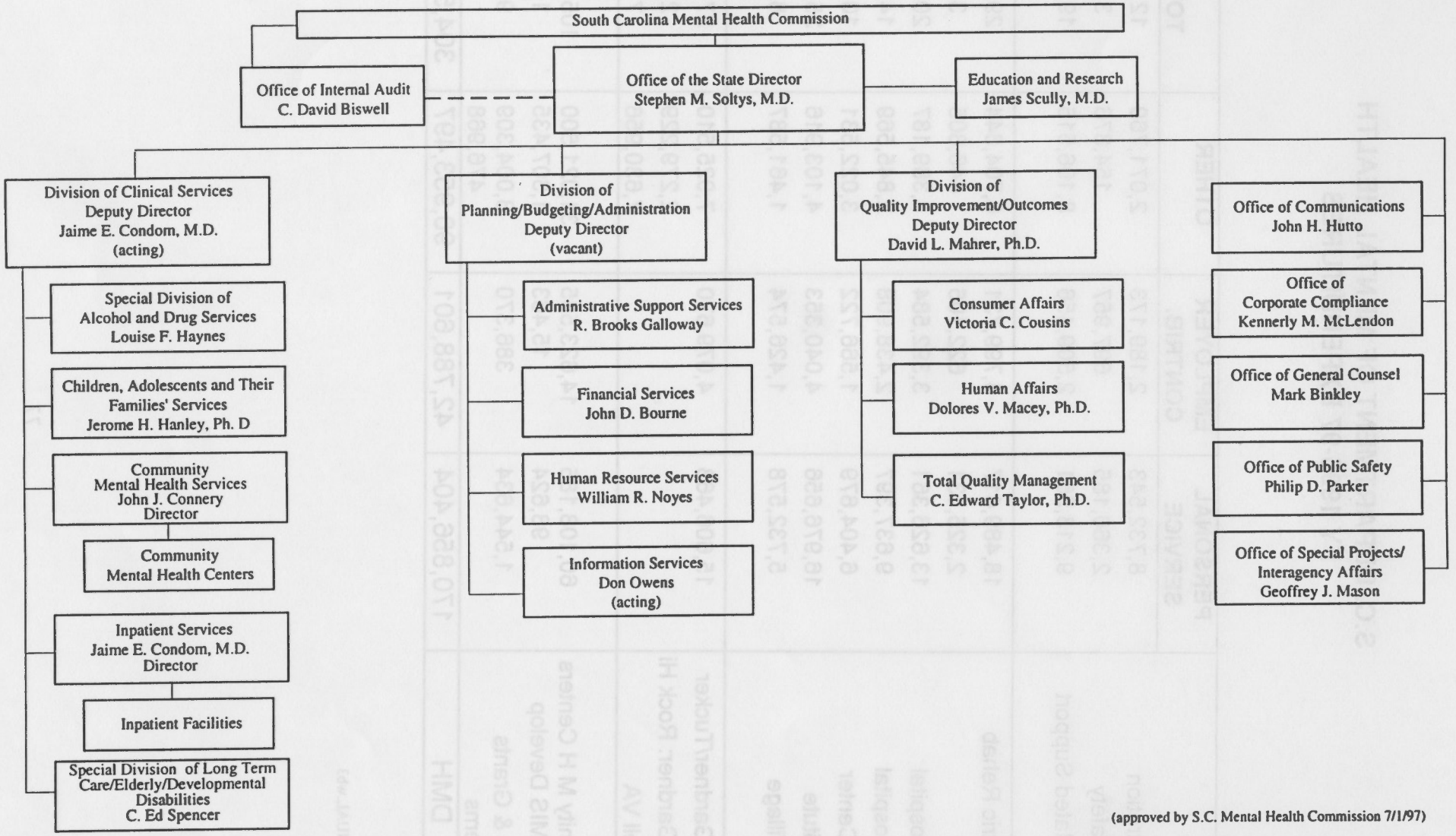
* continue to offer educational advancement to the facility's veterans through Life University; and

* continue to recognize and acknowledge the outstanding Family Support Group of our facility; this group financially supported the installation of automatic doors for this facility through the proceeds from the sale of their cookbooks.

Dowdy Gardner Nursing Care Center/Rock Hill

This facility was closed in November 1996 after residents were relocated to Columbia facilities.

S.C. DEPARTMENT OF MENTAL HEALTH



(approved by S.C. Mental Health Commission 7/1/97)

S.C. DEPARTMENT OF MENTAL HEALTH
FY 1996-97 EXPENDITURES

	PERSONAL SERVICE	EMPLOYER CONTRIB.	OTHER	TOTAL
Administration	8,732,543	2,189,173	2,071,760	12,993,476
Public Safety	2,360,185	697,957	154,876	3,213,018
Consolidated Support	9,213,551	2,509,456	8,106,515	19,829,522
Psychiatric Rehab	18,489,417	4,799,731	6,704,844	29,993,992
ICF/MR	2,325,131	622,105	446,805	3,394,041
Bryan Hospital	13,626,361	3,392,584	3,389,187	20,408,132
Harris Hospital	9,637,397	2,438,908	2,845,569	14,921,874
Byrnes Center	6,404,679	1,566,722	3,022,531	10,993,932
Hall Institute	16,976,656	4,040,353	4,103,916	25,120,925
Morris Village	5,732,578	1,426,574	1,461,587	8,620,739
Dowdy-Gardner/Tucker	15,606,463	4,079,670	7,925,510	27,611,643
Dowdy-Gardner: Rock Hi			2,279,229	2,279,229
Campbell VA			7,630,956	7,630,956
Community M H Centers	60,108,185	14,623,535	31,021,500	105,753,220
Comm. MIS Develop	98,624	15,463	1,307,435	1,421,522
Projects & Grants	1,544,634	386,370	8,004,309	9,935,313
Other Items			476,968	476,968
TOTAL DMH	170,856,404	42,788,601	90,953,497	304,598,502

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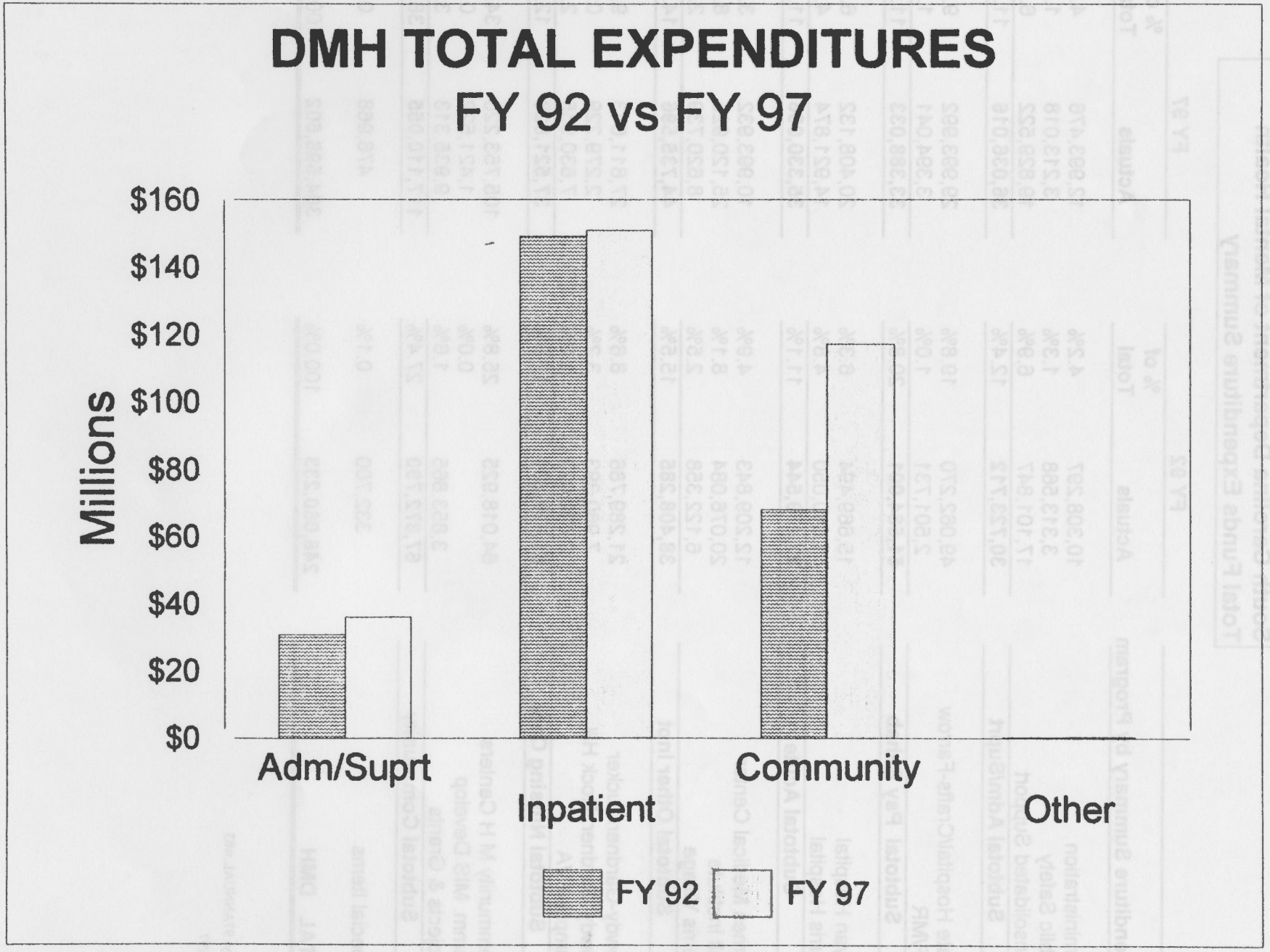
DMH TOTAL EXPENDITURES
FY 92 vs FY 97
Millions
$160
$140
$120
$100
$80
$60
$40
$20
$0
Adm/Suprt
Inpatient
Community
Other
FY 92
FY 97

South Carolina Department of Mental Health
Total Funds Expenditure Summary

Expenditure Summary by Program	FY 92 Actuals	FY 92 % of Total	FY 97 Actuals	FY 97 % of Total
Administration	10,308,297	4.2%	12,993,476	4.3%
Public Safety	3,313,568	1.3%	3,213,018	1.1%
Consolidated Support	17,101,847	6.9%	19,829,522	6.5%
Subtotal Adm/Suprt	**30,723,712**	12.4%	**36,036,016**	11.8%
State Hospital/Crafts-Farrow	49,062,270	19.8%	29,993,992	9.8%
ICF/MR	2,501,731	1.0%	3,394,041	1.1%
Subtotal Psy Rehab	**51,564,001**	20.8%	**33,388,033**	11.0%
Bryan Hospital	15,669,494	6.3%	20,408,132	6.7%
Harris Hospital	11,810,050	4.8%	14,921,874	4.9%
Subtotal Acute	**27,479,544**	11.1%	**35,330,006**	11.6%
Byrnes Medical Center	12,209,843	4.9%	10,993,932	3.6%
Hall Institute	20,076,084	8.1%	25,120,925	8.2%
Morris Village	6,122,358	2.5%	8,620,739	2.8%
Subtotal Other Inpt	**38,408,285**	15.5%	**44,735,596**	14.7%
Dowdy-Gardner/Tucker	21,289,786	8.6%	27,611,643	9.1%
Dowdy-Gardner: Rock Hill	7,960,393	3.2%	2,279,229	0.7%
Campbell VA	2,429,022	1.0%	7,630,956	2.5%
Subtotal Nursing Care	**31,679,201**	12.8%	**37,521,828**	12.3%
Community M H Centers	64,018,925	25.8%	105,753,220	34.7%
Comm. MIS Develop		0.0%	1,421,522	0.5%
Projects & Grants	3,853,865	1.6%	9,935,313	3.3%
Subtotal Community	**67,872,790**	27.4%	**117,110,055**	38.4%
Special Items	332,700	0.1%	476,968	0.2%
TOTAL DMH	**248,060,233**	100.0%	**304,598,502**	100.0%

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SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
COMMUNITY MENTAL HEALTH SERVICES
FISCAL YEAR 1996-1997 REF: AR2MST00

CMHC	TOTAL ADMS	CLINICAL SERVICE ADMS	LIMITED CONTACT ADMS	TOTAL DSGS	CLINICAL ACTIVE CASES ON 6-30-97	TOTAL NUMBER SERVED
AIKEN	2,396	1,471	925	2,195	1,788	4,283
CATAWBA	2,760	1,695	1,065	2,664	2,141	4,942
COLUMBIA AREA	4,387	2,022	2,365	4,109	4,189	8,512
LEXINGTON	2,656	2,622	34	2,586	1,976	4,571
AND-OCON-PICK	5,146	4,431	715	4,779	4,530	9,421
BECKMAN	2,430	1,713	717	2,434	2,371	4,992
GREENVILLE	2,134	2,015	119	1,944	2,781	4,749
PIEDMONT	1,671	1,557	114	1,539	1,767	3,327
SPARTANBURG	2,921	2,401	520	2,787	3,719	6,585
PEE DEE	2,778	1,632	1,146	2,543	2,081	4,932
SANTEE-WATEREE	3,186	2,157	1,029	2,475	4,089	7,045
TRI-COUNTY	1,627	1,226	401	1,478	1,418	2,954
WACCAMAW	3,966	3,134	832	3,588	3,473	7,241
BERKELEY	1,735	1,702	33	1,545	1,605	3,155
CHASTN/DORCH	2,888	2,561	327	2,501	3,611	6,213
COASTAL EMPIRE	1,838	1,265	573	1,800	1,640	3,597
ORANGEBURG	1,652	1,578	74	1,476	2,055	3,558
TOTAL	46,171	35,182	10,989	42,443	45,234	90,077

Psychiatric Hospital Admissions Rates per 100,000 Population
Fiscal Year 1996 vs Fiscal Year 1997

	FY96	FY97		
	Rate	# of Adms	Rate	Variance
REGION A	**229.3**	**2,388**	**255.4**	**26.0**
Aiken-Barnwell	171.7	271	166.6	-5.1
Catawba	168.1	415	173.5	5.4
Columbia Area	342.4	1,326	400.3	57.9
Lexington	161.3	376	186.1	24.8
REGION B	**193.2**	**2,680**	**218.1**	**24.9**
Anderson-Oconee-Pickens	218.7	784	239.2	20.5
Beckman	183.9	513	223.5	39.7
Greenville	203.8	324	177.4	-26.4
Piedmont	151.0	246	149.9	-1.1
Greenville/Piedmont	23.9	170	49.0	25.1
Spartanburg	163.9	643	197.9	34.0
REGION C	**215.1**	**1,966**	**249.6**	**34.4**
Pee Dee	211.4	570	248.6	37.2
Santee-Wateree	213.5	531	255.4	41.9
Tri-County	278.9	279	278.9	-0.1
Waccamaw	194.2	586	233.9	39.7
REGION D	**65.9**	**771**	**91.2**	**25.3**
Berkeley	57.0	166	113.4	56.4
Charleston/Dorchester	46.1	217	56.0	9.9
Coastal Empire	102.6	250	131.1	28.5
Orangeburg	83.4	138	114.2	30.8
THE STATE	**179.2**	**7,831**	**206.2**	**27.0**

SCDMH Psychiatric Admissions:
Includes all admissions to SCSH, CFSH and Bryan.
Includes all Harris admissions except those on A/D papers.
Includes the Children's Unit admissions at WSHPI.
Population figures were used to calculate the annualized admission rates.
The variance is the difference between the FY96 and FY97 rates.

REF: P1FY9697.WB2
DIRM, PDR
29 JUL 97
FILE CODE A-2

Psychiatric Readmission Rates to Psychiatric Hospitals
Fiscal Year 1996 vs Fiscal Year 1997

	FY96	FY97		
	Rate	# of Adms	Rate	Variance
REGION A	**59.4**	**1,503**	**62.9**	**3.5**
Aiken-Barnwell	48.9	149	55.0	6.1
Catawba	48.6	222	53.5	4.9
Columbia Area	69.4	914	68.9	-0.4
Lexington	46.9	218	58.0	11.1
REGION B	**52.6**	**1,385**	**51.7**	**-0.9**
Anderson-Oconee-Pickens	50.8	422	53.8	3.0
Beckman	58.0	265	51.7	-6.3
Greenville	60.6	175	54.0	-6.6
Piedmont	53.9	115	46.7	-7.2
Greenville/Piedmont	54.9	92	54.1	-0.8
Spartanburg	44.0	316	49.1	5.1
REGION C	**52.3**	**998**	**50.8**	**-1.6**
Pee Dee	55.5	315	55.3	-0.3
Santee-Wateree	50.6	271	51.0	0.5
Tri-County	62.6	144	51.6	-11.0
Waccamaw	44.8	268	45.7	0.9
REGION D	**53.6**	**377**	**48.9**	**-4.7**
Berkeley	43.9	66	39.8	-4.1
Charleston/Dorchester	57.3	121	55.8	-1.5
Coastal Empire	55.7	110	44.0	-11.7
Orangeburg	51.0	80	58.0	7.0
THE STATE	**54.8**	**4,278**	**54.6**	**-0.2**

SCDMH Psychiatric Admissions:
Includes all readmissions to SCSH, CFSH & Bryan.
Includes readmissions to Harris on psych papers.
Includes the Children's Unit readmissions at WSHPI.
The rate is the percentage of total psychiatric admissions that are readmissions.
The variance is the difference between the FY 96 and FY 97 rates.

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30 JUL 97
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SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

HOSPITAL SERVICES

FISCAL YEAR 1996-1997

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1996	1221	860	2081
IN HOSPITAL	1155	825	1980
BMC/AREA HOSPITALS	23	14	37
ON LEAVE	0	1	1
ON PASS	43	20	63
FIRST ADMISSIONS	3185	2185	5370
READMISSIONS	4017	2179	6196
TOTAL ADMISSIONS	7202	4364	11566
TRANSFERS IN	223	180	403
RETURNS FROM EFF	37	12	49
RETURNS FROM EFP	4	10	14
TOTAL RECEIVED	7466	4566	12032
EFF'S	42	14	56
EFP'S	4	9	13
ADMINISTRATIVE DISCHARGES	8	1	9
REGULAR DISCHARGES	7090	4321	11411
DEATHS	122	87	209
TRANSFERS OUT	225	180	405
TOTAL SEPARATED	7491	4612	12103
STATISTICAL DISCHARGES	3	1	4
AVERAGE DAILY CENSUS	1191	833	2024
AVG LOS (IN DAYS) OF ALL RELEASES	53.9	93.6	69.0
RESIDENTS ON JUNE 30, 1997	1200	803	2003
IN HOSPITAL	1127	761	1888
BMC/AREA HOSPITALS	34	24	58
ON LEAVE	5	3	8
ON PASS	34	15	49

Due to corrections and effective dates, figures may not add down.

Ref: AR1GENSTAT
OIS, PDR
21 Aug 1997

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

PSYCHIATRIC HOSPITALS

FISCAL YEAR 1996-1997

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1996	620	354	974
IN HOSPITAL	569	333	902
BMC/AREA HOSPITALS	9	3	12
ON LEAVE	0	1	1
ON PASS	42	17	59
FIRST ADMISSIONS	2150	1739	3889
READMISSIONS	2994	1713	4707
TOTAL ADMISSIONS	5144	3452	8596
TRANSFERS IN	208	150	358
RETURNS FROM EFF	22	9	31
RETURNS FROM EFP	4	9	13
TOTAL RECEIVED	5378	3620	8998
EFF'S	24	11	35
EFP'S	4	8	12
ADMINISTRATIVE DISCHARGES	2	0	2
REGULAR DISCHARGES	5112	3447	8559
DEATHS	19	11	30
TRANSFERS OUT	210	153	363
TOTAL SEPARATED	5371	3630	9001
STATISTICAL DISCHARGES	3	1	4
AVERAGE DAILY CENSUS	609	346	955
AVG LOS (IN DAYS) OF ALL RELEASES	32.7	32.1	32.4
RESIDENTS ON JUNE 30, 1997	624	339	963
IN HOSPITAL	575	315	890
BMC/AREA HOSPITALS	10	9	19
ON LEAVE	5	3	8
ON PASS	34	12	46

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SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH
CHANGE IN HOSPITAL AVERAGE DAILY CENSUS
BASED ON TRUE PATIENT DAYS
FY92 vs FY97

FACILITY	FY 92	FY 97	NBR CHANGE	PCT CHANGE
PSYCHIATRIC: Short-Term				
HPH	140	121	-19	-13%
BPH	167	185	18	11%
WSHPI	113	182	69	61%
	420	**488**	**68**	**16%**
Long-Term				
SCSH	463	362	-101	-21%
CFSH	428	54	-374	-87%
	891	**416**	**-475**	**-53%**
SPECIALTY:				
MV	154	133	-21	-13%
BMC	71	37	-34	-47%
	225	**170**	**-55**	**-24%**
NURSING:				
THRC	366	509	143	39%
DGNCC	439	123	-316	-71%
RMCVNH	87	213	126	145%
	892	**845**	**-47**	**-5%**
DMH TOTAL	**2,428**	**1,919**	**-509**	**-20%**

OIS,PDR
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ADMISSIONS, DISCHARGES, IN-HOSPITAL RESIDENTS
FISCAL YEAR 1996-97

FACILITY	ADMISSIONS/ TRANSFERS IN	REGULAR DISCHARGES	RESIDENTS JUNE 30	AVERAGE DAILY CENSUS
PSYCHIATRIC: Short-Term				
HPH	2,906	2,864	121	134
BPH	4,568	4,433	198	207
WSHPI	1,077	1,038	211	200
Long-Term				
SCSH	255	148	381	358
CFSH	148	76	52	56
SPECIALTY:				
MV	2,727	2,728	144	145
BMC	687	6	52	37
NURSING:				
THRC	132	8	528	530
DGNCC	65	78	134	165
RMCVNH	69	22	216	215
DIRECTIONS	22	16	18	14

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REF: AR1
August 14, 1997

SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

G. WERBER BRYAN PSYCHIATRIC HOSPITAL

FISCAL YEAR 1996-1997

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1996	129	87	216
IN HOSPITAL	124	84	208
BMC/AREA HOSPITALS	4	1	5
ON LEAVE	0	0	0
ON PASS	1	2	3
FIRST ADMISSIONS	983	864	1847
READMISSIONS	1709	977	2686
TOTAL ADMISSIONS	2692	1841	4533
TRANSFERS IN	14	21	35
RETURNS FROM EFF	4	2	6
RETURNS FROM EFP	1	0	1
TOTAL RECEIVED	2711	1864	4575
EFF'S	5	3	8
EFP'S	1	0	1
ADMINISTRATIVE DISCHARGES	0	0	0
REGULAR DISCHARGES	2635	1798	4433
DEATHS	9	2	11
TRANSFERS OUT	86	54	140
TOTAL SEPARATED	2736	1857	4593
STATISTICAL DISCHARGES	2	0	2
AVERAGE DAILY CENSUS	119	88	207
AVG LOS (IN DAYS) OF ALL RELEASES	16.8	16.9	16.9
RESIDENTS ON JUNE 30, 1997	104	94	198
IN HOSPITAL	99	87	186
BMC/AREA HOSPITALS	5	5	10
ON LEAVE	0	0	0
ON PASS	0	2	2

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SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

RICHARD M. CAMPBELL VETERANS NURSING HOME

FISCAL YEAR 1996-1997

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1996	207	7	214
IN HOSPITAL	205	7	212
BMC/AREA HOSPITALS	2	0	2
ON LEAVE	0	0	0
ON PASS	0	0	0
FIRST ADMISSIONS	58	1	59
READMISSIONS	10	0	10
TOTAL ADMISSIONS	68	1	69
TRANSFERS IN	0	0	0
RETURNS FROM EFF	0	0	0
RETURNS FROM EFP	0	0	0
TOTAL RECEIVED	68	1	69
EFF'S	0	0	0
EFP'S	0	0	0
ADMINISTRATIVE DISCHARGES	0	0	0
REGULAR DISCHARGES	22	0	22
DEATHS	43	2	45
TRANSFERS OUT	0	0	0
TOTAL SEPARATED	65	2	67
STATISTICAL DISCHARGES	0	0	0
AVERAGE DAILY CENSUS	209	6	215
AVG LOS (IN DAYS) OF ALL RELEASES	809.3	1464.0	828.9
RESIDENTS ON JUNE 30, 1997	210	6	216
IN HOSPITAL	209	6	215
BMC/AREA HOSPITALS	1	0	1
ON LEAVE	0	0	0
ON PASS	0	0	0

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SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

CRAFTS-FARROW STATE HOSPITAL

FISCAL YEAR 1996-1997

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1996	36	47	83
IN HOSPITAL	32	43	75
BMC/AREA HOSPITALS	0	2	2
ON LEAVE	0	0	0
ON PASS	4	2	6
FIRST ADMISSIONS	17	25	42
READMISSIONS	19	26	45
TOTAL ADMISSIONS	36	51	87
TRANSFERS IN	34	27	61
RETURNS FROM EFF	1	0	1
RETURNS FROM EFP	0	1	1
TOTAL RECEIVED	71	79	150
EFF'S	1	0	1
EFP'S	0	1	1
ADMINISTRATIVE DISCHARGES	0	0	0
REGULAR DISCHARGES	31	45	76
DEATHS	0	1	1
TRANSFERS OUT	46	57	103
TOTAL SEPARATED	78	104	182
STATISTICAL DISCHARGES	0	0	0
AVERAGE DAILY CENSUS	28	28	56
AVG LOS (IN DAYS) OF ALL RELEASES	342.5	325.4	332.7
RESIDENTS ON JUNE 30, 1997	30	22	52
IN HOSPITAL	30	22	52
BMC/AREA HOSPITALS	0	0	0
ON LEAVE	0	0	0
ON PASS	0	0	0

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SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

DOWDY-GARDNER NURSING CARE CENTER

FISCAL YEAR 1996-1997

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1996	72	137	209
IN HOSPITAL	71	135	206
BMC/AREA HOSPITALS	1	2	3
ON LEAVE	0	0	0
ON PASS	0	0	0
FIRST ADMISSIONS	0	0	0
READMISSIONS	19	40	59
TOTAL ADMISSIONS	19	40	59
TRANSFERS IN	3	3	6
RETURNS FROM EFF	0	0	0
RETURNS FROM EFP	0	0	0
TOTAL RECEIVED	22	43	65
EFF'S	0	0	0
EFP'S	0	0	0
ADMINISTRATIVE DISCHARGES	0	0	0
REGULAR DISCHARGES	18	60	78
DEATHS	13	13	26
TRANSFERS OUT	12	24	36
TOTAL SEPARATED	43	97	140
STATISTICAL DISCHARGES	0	0	0
AVERAGE DAILY CENSUS	61	104	165
AVG LOS (IN DAYS) OF ALL RELEASES	1762.4	2112.6	2005.0
RESIDENTS ON JUNE 30, 1997	52	82	134
IN HOSPITAL	47	78	125
BMC/AREA HOSPITALS	5	4	9
ON LEAVE	0	0	0
ON PASS	0	0	0

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SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

WILLIAM S. HALL PSYCHIATRIC INSTITUTE

FISCAL YEAR 1996-1997

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1996	152	37	189
IN HOSPITAL	117	28	145
BMC/AREA HOSPITALS	0	0	0
ON LEAVE	0	0	0
ON PASS	35	9	44
FIRST ADMISSIONS	402	212	614
READMISSIONS	333	127	460
TOTAL ADMISSIONS	735	339	1074
TRANSFERS IN	3	0	3
RETURNS FROM EFF	7	3	10
RETURNS FROM EFP	0	0	0
TOTAL RECEIVED	745	342	1087
EFF'S	7	3	10
EFP'S	0	0	0
ADMINISTRATIVE DISCHARGES	1	0	1
REGULAR DISCHARGES	701	337	1038
DEATHS	1	0	1
TRANSFERS OUT	11	1	12
TOTAL SEPARATED	721	341	1062
STATISTICAL DISCHARGES	0	0	0
AVERAGE DAILY CENSUS	163	37	200
AVG LOS (IN DAYS) OF ALL RELEASES	32.3	16.3	27.2
RESIDENTS ON JUNE 30, 1997	174	37	211
IN HOSPITAL	148	32	180
BMC/AREA HOSPITALS	1	0	1
ON LEAVE	0	0	0
ON PASS	25	5	30

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SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

DIRECTIONS AT WSHPI

FISCAL YEAR 1996-1997

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1996	3	10	13
IN HOSPITAL	2	9	11
BMC/AREA HOSPITALS	0	0	0
ON LEAVE	0	0	0
ON PASS	1	1	2
FIRST ADMISSIONS	2	8	10
READMISSIONS	3	8	11
TOTAL ADMISSIONS	5	16	21
TRANSFERS IN	0	1	1
RETURNS FROM EFF	0	1	1
RETURNS FROM EFP	0	1	1
TOTAL RECEIVED	5	19	24
EFF'S	0	0	0
EFP'S	0	1	1
ADMINISTRATIVE DISCHARGES	0	1	1
REGULAR DISCHARGES	4	12	16
DEATHS	0	0	0
TRANSFERS OUT	0	0	0
TOTAL SEPARATED	4	14	18
STATISTICAL DISCHARGES	0	0	0
AVERAGE DAILY CENSUS	3	11	14
AVG LOS (IN DAYS) OF ALL RELEASES	183.2	185.8	185.2
RESIDENTS ON JUNE 30, 1997	4	14	18
IN HOSPITAL	4	13	17
BMC/AREA HOSPITALS	0	0	0
ON LEAVE	0	0	0
ON PASS	0	1	1

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SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

PATRICK B. HARRIS PSYCHIATRIC HOSPITAL

FISCAL YEAR 1996-1997

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1996	87	61	148
IN HOSPITAL	85	61	146
BMC/AREA HOSPITALS	2	0	2
ON LEAVE	0	0	0
ON PASS	0	0	0
FIRST ADMISSIONS	746	637	1383
READMISSIONS	932	582	1514
TOTAL ADMISSIONS	1678	1219	2897
TRANSFERS IN	4	5	9
RETURNS FROM EFF	0	1	1
RETURNS FROM EFP	1	0	1
TOTAL RECEIVED	1683	1225	2908
EFF'S	0	1	1
EFP'S	1	0	1
ADMINISTRATIVE DISCHARGES	1	0	1
REGULAR DISCHARGES	1657	1207	2864
DEATHS	2	3	5
TRANSFERS OUT	39	19	58
TOTAL SEPARATED	1700	1230	2930
STATISTICAL DISCHARGES	0	0	0
AVERAGE DAILY CENSUS	70	64	134
AVG LOS (IN DAYS) OF ALL RELEASES	15.7	18.2	16.8
RESIDENTS ON JUNE 30, 1997	68	53	121
IN HOSPITAL	68	53	121
BMC/AREA HOSPITALS	0	0	0
ON LEAVE	0	0	0
ON PASS	0	0	0

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SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

EARLE E. MORRIS, JR. ALCOHOL AND DRUG TREATMENT CENTER

FISCAL YEAR 1996-1997

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1996	110	44	154
IN HOSPITAL	108	43	151
BMC/AREA HOSPITALS	2	1	3
ON LEAVE	0	0	0
ON PASS	0	0	0
FIRST ADMISSIONS	967	433	1400
READMISSIONS	960	365	1325
TOTAL ADMISSIONS	1927	798	2725
TRANSFERS IN	0	2	2
RETURNS FROM EFF	15	2	17
RETURNS FROM EFP	0	0	0
TOTAL RECEIVED	1942	802	2744
EFF'S	18	3	21
EFP'S	0	0	0
ADMINISTRATIVE DISCHARGES	6	0	6
REGULAR DISCHARGES	1929	799	2728
DEATHS	0	1	1
TRANSFERS OUT	0	0	0
TOTAL SEPARATED	1953	803	2756
STATISTICAL DISCHARGES	0	0	0
AVERAGE DAILY CENSUS	99	46	145
AVG LOS (IN DAYS) OF ALL RELEASES	18.7	20.1	19.1
RESIDENTS ON JUNE 30, 1997	101	43	144
IN HOSPITAL	100	42	142
BMC/AREA HOSPITALS	1	1	2
ON LEAVE	0	0	0
ON PASS	0	0	0

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SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

SOUTH CAROLINA STATE HOSPITAL

FISCAL YEAR 1996-1997

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1996	216	122	338
IN HOSPITAL	211	117	328
BMC/AREA HOSPITALS	3	0	3
ON LEAVE	0	1	1
ON PASS	2	4	6
FIRST ADMISSIONS	2	1	3
READMISSIONS	1	1	2
TOTAL ADMISSIONS	3	2	5
TRANSFERS IN	153	97	250
RETURNS FROM EFF	10	3	13
RETURNS FROM EFP	2	8	10
TOTAL RECEIVED	168	110	278
EFF'S	11	4	15
EFP'S	2	7	9
ADMINISTRATIVE DISCHARGES	0	0	0
REGULAR DISCHARGES	88	60	148
DEATHS	7	5	12
TRANSFERS OUT	28	22	50
TOTAL SEPARATED	136	98	234
STATISTICAL DISCHARGES	1	1	2
AVERAGE DAILY CENSUS	229	129	358
AVG LOS (IN DAYS) OF ALL RELEASES	427.0	265.0	359.9
RESIDENTS ON JUNE 30, 1997	248	133	381
IN HOSPITAL	230	121	351
BMC/AREA HOSPITALS	4	4	8
ON LEAVE	5	3	8
ON PASS	9	5	14

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SOUTH CAROLINA DEPARTMENT OF MENTAL HEALTH

GENERAL STATISTICS

C. M. TUCKER, JR. HUMAN RESOURCES CENTER

FISCAL YEAR 1996-1997

TRANSACTIONS	MALE	FEMALE	TOTAL
RESIDENTS ON JULY 1, 1996	209	308	517
IN HOSPITAL	200	298	498
BMC/AREA HOSPITALS	9	8	17
ON LEAVE	0	0	0
ON PASS	0	2	2
FIRST ADMISSIONS	8	4	12
READMISSIONS	31	53	84
TOTAL ADMISSIONS	39	57	96
TRANSFERS IN	12	24	36
RETURNS FROM EFF	0	0	0
RETURNS FROM EFP	0	0	0
TOTAL RECEIVED	51	81	132
EFF'S	0	0	0
EFP'S	0	0	0
ADMINISTRATIVE DISCHARGES	0	0	0
REGULAR DISCHARGES	5	3	8
DEATHS	47	60	107
TRANSFERS OUT	3	3	6
TOTAL SEPARATED	55	66	121
STATISTICAL DISCHARGES	0	0	0
AVERAGE DAILY CENSUS	210	320	530
AVG LOS (IN DAYS) OF ALL RELEASES	1116.3	1318.9	1226.8
RESIDENTS ON JUNE 30, 1997	209	319	528
IN HOSPITAL	192	307	499
BMC/AREA HOSPITALS	17	10	27
ON LEAVE	0	0	0
ON PASS	0	2	2

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